PROVINCIAL SENIOR CITIZENS ADVISORY COUNCIL

ANNUAL REPORT 1982

Report submitted to the Honourable Neil Webber,
Minister of Alberta Social Services and Community Health

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EXECUTIVE SUMMARY

The Council's 1982 report is based on the activities of the past year — the Alberta Symposium on Aging, the development of two discussion papers and the involvement of the chairman in the United Nations World Assembly on Aging. The major thrusts in this report are from the Symposium and are similar to those of past Council reports, the Nursing Home Review Panel report, the United Nations World Assembly on Aging and the 1981 Report of the National Advisory Council on Aging.

Three priority recommendations are presented:

1. The Ministers of Social Services and Community Health and Hospitals and Medical Care are asked to develop a greater range of alternatives to institutional care for the elderly. Specifically mentioned is the expansion of the present Co-ordinated Home Care program so that persons who are frail and disabled who require only a support service are eligible for care. Day care, day hospitals and respite care (temporary care) are also seen as important in maintaining "independence" and helping family members care for elderly persons. The development of these services is seen as not only maintaining families but as, in the long run, being less costly than the present emphasis on institutional services. In 1979/80, out of the total provincial expenditure on health and social services for persons 65 and over, only 1.6 percent was for community services, including the Co-ordinated Home Care Program.
2. The Ministers of Social Services and Community Health, Hospitals and Medical Care, Housing and Recreation and Parks are asked to support in principle a more co-ordinated system of service delivery at the local or regional level to better meet the needs of older persons. The present system, with three major programs providing service to a relatively small group of elderly, is described. The Council proposes ways of improving this fragmentation, suggesting that greater co-ordination is essential to improve service and restrain costs.
3. The Ministers of Social Services and Community Health, Labour, Federal and Intergovernmental Affairs and the Provincial Treasurer are asked to continue to provide a base minimum income for lower income pensioners and support specific improvements in the Canada Pension Plan and in the private pension sector.

The remaining section of the report contains a review of the observations and recommendations from the Alberta Symposium on Aging which are supported by the Council. They are presented as "issues of concern."

INTRODUCTION

The Council's 1982 report flows from its activities this year: its sponsorship of the Alberta Symposium on Aging held from May 31 – June 3, its review of the Report and Recommendations of the Nursing Home Review Panel, its development of two background papers, one on "Death and Dying and Older Persons" and one on "Human Rights and Older Persons" and the involvement of its chairman in the United Nations World Assembly on Aging as a member of the Canadian delegation.

The Symposium, the purpose of which was to develop "Guidelines for the Eighties," brought together a wide variety of knowledgeable persons concerned with aging and the aged including experts invited from across North America, senior citizens, academics, service providers, members of the business and religious communities and major voluntary groups, civil servants and politicians. The Proceedings of the Symposium contain the expert papers by six keynote speakers and twenty-three panelists as well as summaries of the workshop discussions on six topics: Retirement Policy and Income Support; Strengthening Personal Support Systems; Opportunities in Retirement; Advocacy and Self-Determination; Research and Education; and Needs and Related Services.

The major thrusts from the Symposium form the basis of this report. Copies of the submission on the Symposium prepared by the Planning Committee and submitted through the Council to the Minister and the Proceedings of the Symposium are available from the Senior Citizens Bureau.1

In the Spring of 1982 the Nursing Home Review Panel, a committee appointed by the Minister of Hospitals and Medical Care, released its report. The Council submitted comments on the report to the Minister of Hospitals and Medical Care which form Appendix A. During this year background papers on "Human Rights and Older Persons" and "Death, Dying and the Elderly" were prepared. They are included as Appendix B and Appendix C, and issues raised from them are incorporated in this report. The paper on human rights contains a recommendation to the Minister of Labour.

The United Nations World Assembly on Aging, held in Vienna, Austria from July 26 to August 6, 1982, developed an International Plan of Action on Aging which has been adopted by the General Assembly of the United Nations. The chairman of the Council attended this Assembly as a member of the Canadian delegation. His report forms Appendix D.

Last year the Council suggested a "new approach" to aging and the aged — "a shift in emphasis from crisis palliatives to prevention ... Our emphasis in future therefore, should be on encouraging aging persons to continue as an integral part of the community they know — the family, the neighbourhood, the working world and not as a group set aside." The reader of this report is encouraged to review the argument made last year in describing the new concept. It is interesting to note that during the Symposium the presentation and discussions of the keynote speakers, panelists and workshop participants were centered primarily on prevention. Indeed very little reference was made to "institutional" care. This seems to indicate that the participants were convinced that it is time to re-examine what we are doing.

The Vienna Plan of Action has a similar thrust. In the Preamble to the Plan the participating countries "solemnly recognize that quality of life is no less important than longevity, and that the aging should therefore, as far as possible, be enabled to enjoy in their own families and communities a life of fulfilment, health, security, and contentment, appreciated as an integral part of society."

The Report of the National Advisory Council on Aging, **Priorities for Action**, was released in late 1981 and contains recommendations which also support this emphasis.

The Nursing Home Review Panel in its report of March 1982 stated in its philosophy: "The care of the elderly and disabled must be based on respect for the individual as an independent member of society who has the right to make decisions about his or her life and to function with those choices in as normal a setting as possible. For most of the frail and elderly needing minimal care, this can best be achieved through care services that allow the individual to remain at home."

These statements support our conviction that a "new approach" is needed especially with the increasing numbers of elderly (see Graph 1). This year's report therefore reviews the recommendations and observations from the Symposium within the same conceptual framework as that developed in the 1981 report. Briefly these recommendations are divided into:

1. "developmental" issues — the influences, the attitudes, the policies and the services that give older people opportunities for continued involvement in living;
2. "supportive" issues — the development and delivery of services needed to help older persons utilize their strengths with the least amount of outside interference without creating unnecessary dependency; and
3. "protective" issues — the ways to provide a sheltered and protected environment with appropriate care and rehabilitation.

Out of the many recommendations and observations from the Symposium, from the report of the Nursing Home Review Panel and from its own past reports, the Council has chosen three recommendations to emphasize and present as priorities to the Government of Alberta. The remaining material is presented as "Issues of Concern."

In previous years our reports have mentioned cost effectiveness but perhaps it has not had the prominence it deserves. There is little doubt that if the recommendations in this and previous reports were implemented there would be a significant overall saving to government and subsequently to the public. Cost effectiveness will receive more emphasis this year as we continue through a period of recession. COUNCIL IS NOT SIMPLY ADVOCATING MORE SERVICES – IT IS ADVOCATING A SHIFT IN SERVICES THAT WILL NOT ONLY REDUCE GOVERNMENT INVOLVEMENT AND SUPPORT BUT WILL ADD TO THE INDEPENDENCE OF FUTURE GENERATIONS OF OLDER PEOPLE.

Responding to recommendations from the Symposium on Aging and the Nursing Home Review Panel, the Council again requested the establishment of an Alberta Institute on Aging, asking that the proposal for an Institute be submitted to the Standing Committee on the Alberta Heritage Savings Trust Fund Act as a project to be funded through an initial endowment. The Council sees this as separate from its other recommendations as it involves an initial endowment only and is a project that will have not immediate but rather long range benefits for Alberta and Canada. The Council's submission is contained in Appendix E.

THREE PRIORITY RECOMMENDATIONS

RECOMMENDATION ONE

TO THE MINISTER OF SOCIAL SERVICES AND COMMUNITY HEALTH AND THE MINISTER OF HOSPITALS AND MEDICAL CARE

ALTERNATIVES TO INSTITUTIONAL CARE

The Council recommends that a greater range for older persons of alternatives to institutions be developed who are frail and disabled:

- that the Co-ordinated Home Care program be extended to persons who are frail and disabled, who do not necessarily need a professional health service but need support services only and that these support services be considered an integral part of Home Care;
- that day programs (day hospitals and adult day care services) be developed and funded using existing services such as senior centres, lodges, nursing homes and auxiliary hospitals;
- that respite care (temporary care for older persons) be developed through the flexible utilization of all existing programs including lodges, nursing homes and home care.

Council is convinced that older people want to stay in the community, in their own homes, with as much independence as possible and for as long as possible. Care in an institution should be used only when the person is in need of shelter as well as extensive services, and all community alternatives have been explored and exhausted.

However, to ensure this, care of family and friends is not enough. We need alternative forms of care which can support and help family and friends. Among these alternatives are expanded home care, day care and respite care.

To date, supports such as day care, day hospitals[2] and respite care have been lacking in Alberta, and the Co-ordinated Home Care[3] program has been limited to providing help only when the person needs a professional health service. While some additional help has been available from homemaker and other services funded through Family and Community Support Services, these as yet are inadequate and are not uniformly available throughout the province. The result is that some older persons go into nursing homes (or lodges) because they are unable to obtain support services or personal care services.

This conclusion has resulted from our own observations as well as from studies of older persons, expert opinions, recommendations from the Alberta Symposium on Aging and the Report of the Nursing Home Review Panel.[4]

At the present time our resources are primarily directed toward institutional care. The vast majority of the expenditures on health and social services for older persons in Alberta are being used by a very small percentage of the older population and are being used for

care in active treatment hospitals and long term care institutions. In 1979/80, 57.6 per cent of the health and social service expenditures for persons 65 and over were used for care in active treatment hospitals and 32.9 per cent for care in long term care institutions; 7.9 per cent went for medical services (doctors) and only 1.6 per cent for community services including the Co-ordinated Home Care Program (see figure 1).[5] Alberta is not unique in this as was pointed out by keynote speakers at the Alberta Symposium and in the Report of the North American Regional Technical meeting in preparation for the World Assembly on Aging. In the United States 4 per cent of funding goes for community health and related services, while 96 per cent goes for institutional services.[6]

We are further convinced of the need for alternative services as a result of the Manitoba/Canada Home Care study[7] which shows dramatically the economic advantages (as well as the social advantages) of using alternatives to institutional care — in particular, using a home care program with a major component of support services. In one month the home care program resulted in a saving of 1.19 million dollars for the 1,167 clients studied. These clients included not only those who otherwise would have had to use institutional care, but also those who would have gone without service since no suitable service would have been available. In addition to representing a major saving, the home care program provided service to many persons for whom institutionalization would not have been appropriate.[8]

Perhaps the most important reason for our recommendation concerning alternatives to institutional care is our belief in the need to strengthen and support family and community life for older persons. We know that families are important to older persons and that they do care and provide much service to them. However, as was brought out in the Symposium, families also need support, especially families caring for older persons with mental health problems.[9] The families as well as the older persons need the help and support of alternative services in order to continue to provide the best care of which they are capable. An excessive reliance on institutional care, particularly institutional care that is heavily subsidized, destroys or at best weakens family support. It also creates a situation where institutionalization becomes an economic advantage.

RECOMMENDATION TWO:

TO THE MINISTER OF SOCIAL SERVICES AND COMMUNITY HEALTH, THE MINISTER OF HOSPITALS AND MEDICAL CARE, THE MINISTER OF HOUSING AND THE MINISTER OF RECREATION AND PARKS

CO-ORDINATION OF SERVICES

The Council recommends that the Ministers encourage and support in principle a more co-ordinated system of service delivery at the local or regional level to meet more effectively the needs of older persons.

Our previous Council reports, recommendations from the Alberta Symposium on Aging and the Nursing Home Review Panel, and two recent studies commissioned by provincial departments[10] are consistent in suggesting the need for a co-ordinated, integrated system of services for older persons, particularly those who are frail and disabled. Indeed, it is unlikely that we will see any significant advance over what we are now doing (any change in the need for and use of institutional services) until such a system is operating effectively.

Research and experience in other places suggests that the addition of community services makes little difference in the use of long term institutional care unless there is co-ordination between community and institutional care and admission to institutional care is carefully screened and controlled.[11] The Manitoba study, referred to earlier, indicates that Manitoba has a Continuing Care Program of which home care is one part and personal home care placement the other. It is possible, therefore, to assess a person for care and determine if needs can be met most appropriately through home care or through placement. This process, it is believed, produces cost efficiencies in the system.

At present in Alberta we have three major programs providing help to this relatively small group of older persons. They are: the Co-ordinated Home Care program funded by the Department of Social Services and Community Health and administered by the 27 Local Health Authorities (see footnote 3); the support services (homemaker and home help services), funded primarily by the Department of Social Services and Community Health through the Family and Community Support Services program, and developed and administered through the municipalities; and nursing homes and auxiliary hospitals funded by the Department of Hospitals and Medical Care, the planning for and admission to which is administered by local hospital districts. Each program has its own admission criteria, assessment processes and standards and its own administrative and assessment staff.

There are also 121 lodges throughout the province; these are residential homes providing board and room to older persons. The Co-ordinated Home Care program is serving some of the lodge residents. Lodges are administered by municipalities and have their own individual admission criteria and standards.

In addition, some community health nurses and some outreach workers attached to Family and Community Support Services offices and senior centres, as well some recreation staff, are working with these older persons.

The Co-ordinated Home Care program and nursing homes and auxiliary hospitals are available throughout the province. The Family and Community Support Services are limited in funding and not as uniformly available as the others, as each municipality in the program has the freedom to develop services and tailor them to meet the local needs as much as possible (in 1980/81 out of the 60 FCSS programs, 40 had homemaker services).

With the exception of the auxiliary hospitals, the major reason for the provision of any of these services is the need for personal care and support services because of the person's frailty and disability due to a chronic condition or simply old age.

There are several options for implementing this recommendation.

1. Give the authority to one of the above bodies to be the co-ordinating agency in various regions of the province; for example, home care could be the local authority for planning these services and through which persons gain access to all the above services, whether social supports only, or admission to nursing homes and auxiliary hospitals.
2. Another possibility would be to establish a new body — a special co-ordinating authority for continuing care for each region. This was suggested by the Nursing Home Review Panel report and the Symposium on Aging.
3. The third possibility is for each local area (region) to determine what ways best meet its need. The determination of the "area" or "region" might be difficult. However, the Council is prepared to facilitate this process by leading some discussions with interested local authorities, bringing together representatives of the various bodies to seek their advice and direction concerning local co-ordination. It was suggested by Council in the 1979 report that local authorities who are interested in change could be helped to develop a model to test a new way of offering services. Encouragement and funding could be provided by the provincial departments concerned.

It is entirely possible that many persons who are delivering services at the local level will see no need for change, and it is most certainly true that often individual representatives of the services do work well together in spite of the lack of system.

However, the Council is convinced that if we ever want to reverse the present trend towards dependence on institutions, the most costly way of providing service, co-ordinated planning must be done to avoid gaps and the community services must work together to provide a reliable alternative. Until now institutions, because they are operating on a 24 hour basis, have had this responsibility thrust on them. If reliable alternatives can be developed, then institutions could be encouraged not to accept persons until all community alternatives have been explored. "One entry point" to service is also crucial and the only way we can begin to effect a savings in the cost of health and social services for the small group of older persons who are the users of these services. It would avoid the present frustrations some older persons and their families face in determining what they need and in seeking out a service. It would ensure to a greater degree that persons are served appropriately.

Greater co-ordination could result in cost-savings as it would lessen administrative overhead by the sharing of assessment and other resources and would, as the Manitoba study shows and the Symposium and Review Panel report point out, ensure that the greatest degree of independence is maintained. Over-servicing persons by admitting them

to institutional care when less help would be satisfactory or keeping them in such care, especially in active treatment hospitals, when other services might be more appropriate, is extremely costly in both human and financial terms (see footnote 8). The Government has pointed out the need for restraint in funding. In view of this it seems only practical for the Government to begin to provide service to older persons in a more cost-effective way.

RECOMMENDATION THREE

TO THE MINISTER OF SOCIAL SERVICES AND COMMUNITY HEALTH, THE MINISTER OF LABOUR, THE MINISTER OF FEDERAL AND INTERGOVERNMENTAL AFFAIRS AND TO THE PROVINCIAL TREASURER

INCOME SUPPORT AND PENSIONS

The Council recommends that the Federal and Provincial Governments continue to provide a base minimum income for lower income persons 65 and over to ensure that all older persons have an adequate standard of living.

Furthermore, to ensure that future generations of older persons have adequate pension incomes, the Council recommends:

- that the Alberta Government, in its negotiations concerning the Canada Pension Plan, support an increase in the contributions to the Plan, to make it more actuarially sound in order to increase present and future benefits.
- that the Alberta Government encourage the private pension sector to become more active so that private pension plans are more available, effectively meet the needs of the subscribers and include greater vesting and portability.
- that the Alberta Government recommend increasing the amount of tax-free funds that can be put into private pension savings.

This recommendation concerning income support and pensions is based primarily on the observations and recommendations from the Alberta Symposium on Aging workshop on "retirement policy and income support."

The discussions emphasized the responsibility of governments to provide a basic floor income, but also emphasized the responsibility of individuals to add to this through private plans and savings should they wish a higher standard of living.

We believe that the recommendations concerning the Canada Pension Plan and private pensions are most important, for if they are gradually effected there will be less need for income supplementation which is really a form of public subsidy.

Some of the changes in private plans suggested by the Symposium workshop are: improvement in survivors' benefits, vesting and portability; indexing; protection against bankruptcy of the pension plan; and employee involvement in plan administration. Council members are convinced that older persons have a strong sense of responsibility and want to be as independent as possible. However, up to this time, the possibility of financial independence has been limited as pension plans were limited, and the majority have had to rely on federal and provincial income supplementation (Guaranteed Income Supplement and Alberta Assured Income Plan). A strengthening of the Canada Pension Plan and private pension plans will help to ensure that in the future more older persons will be independent and not have to rely on these and other special benefit programs. An adequate income will also help to ensure independence in that persons will not have to seek dependent living situations for financial reasons alone.

ISSUES OF CONCERN

These issues are based on the remaining observations and recommendations from the Alberta Symposium on Aging and the two background papers prepared for the Council. Many are similar to recommendations made by the Council in its past reports.

DEVELOPMENTAL ISSUES

PROTECTION FOR OLDER PERSONS AGAINST NEGATIVE DISCRIMINATION

1. There is a need for a change in the Individual's Right Protection Act, the Alberta Human Rights Legislation. At the present time the Act only protects persons from age 45-64 years against discrimination, and it protects them only in the areas of employment and the displaying of signs and notices. This means that persons 65 years of age and over have no protection against negative discriminatory practices in Alberta. Human rights legislation in several other provinces is broader and offers more comprehensive coverage to persons 65 and over. Appendix B is the background paper, "Human Rights and Older Persons," on which this issue is based. It contains a recommendation to the Minister of Labour.

EXAMINATION OF MANDATORY RETIREMENT AND PROVISION OF WORK OPPORTUNITIES

2. Tied in with the above issue is the need to examine the current practice of mandatory retirement at a fixed chronological age, usually age 65. It is recognized that some persons will want to retire

at age 60 or 65. This would not affect their retirement, but would simply give those few who want to continue working and are able to do so the opportunity to do so. The ability to do the job, not age, should determine the time of retirement. Other considerations would be the development of policies that permit persons to retire gradually and policies that would encourage more work opportunities, including part-time work, for persons in their later years — for example, using older persons (65 and over) on temporary contract work.

Certainly, with the prediction of a decreasing labour force and an increasing retired group, it seems only prudent to take advantage of those older persons who want to, and are able to continue working. Many older people can be productive and valuable employees since they have years of experience and a reputation for being responsible employees with a particular concern for accuracy.

EDUCATION ABOUT AGING

3. There is a continuing need for education of the general public about aging and the needs of older persons. We may never be able to change the ambivalence with which all of us view aging; however, understanding the aging process will help us cope with the changes that will occur both in ourselves and in others. This education should begin with school-age children and continue throughout life. Special emphasis should be given to providing information to persons before they retire, preferably to persons in the middle years, to ensure that they have an understanding of some of the ways of coping most effectively in the later years. This could include information about pensions and savings, maintaining good health, interpersonal relations and coping skills. The media could be used more effectively to promote positive images of older persons.

4. There is a need for education of persons working with the aged from the professional level to the aide level. Gerontology should be included in the curricula of all professional faculties, and particularly those of health and social service personnel. Specific recommendations were made at the Symposium on Aging for the establishment of

a model training centre affiliated with university faculties for multidisciplinary teaching and research and for an increase in the numbers of persons trained in rehabilitation therapy by the Faculty of Rehabilitation Medicine at the University of Alberta. Fellowships should be made available, particularly for physicians, and more continuing education programs developed with increases and promotions provided to staff who participate. Special attention must be given to finding ways of increasing the skill and knowledge level of aides in nursing homes and auxiliary hospitals in Alberta. All educational programs should emphasize the prevention of illness in older persons and the importance of early intervention, treatment and active rehabilitation. Educational programs should also emphasize the need to allow older persons to make decisions about their own lives to the greatest extent possible. So often well-meaning relatives and service-providers take over, assuming that to grow old, and perhaps frail, is to become childlike.

EXPLANATION OF RECREATIONAL, EDUCATIONAL AND VOLUNTEER OPPORTUNITIES

5. There is a need for the promotion of the appropriate use of leisure time in all stages of life. For seniors, there is a need to continue and expand the recreational and educational programs now available to them, finding ways to activate those not usually involved.

   Mental and physical fitness is the key to well-being in the later years, and both recreational and educational activities help to maintain and even improve the fitness of older persons.

   Meaningful volunteer work is an area that could be yet further developed. Surely older persons could themselves be more involved in meeting the needs of some of their frailer peers. To encourage this, however, requires a change in the attitudes of some service-providers — a recognition that older persons have a great deal to give but to be encouraged to do so they must also be listened to and have the opportunity to advise on program development and service delivery. Ways need to be found to ensure that older persons are more involved in advisory and management bodies.

INFORMATION ABOUT SERVICES FOR SENIORS

6. There is a need for more dissemination of information about benefits and services available to seniors. Older persons sometimes miss opportunities, do not take advantage of benefits, or do not receive appropriate help because they do not know what is available.

ATTENTION TO SPIRITUAL NEEDS

7. An often neglected area is attention to the spiritual needs of older persons. We are thinking not only about religious belief and involvement but a positive affirmation of life that gives meaning and wholeness. However, concerning the religious community specifically, it is suggested that special training courses in pastoral care with older persons should be available to clergy, and retired clergy could be encouraged to assist in providing pastoral care.

PREVENTIVE HEALTH SERVICES

8. As mentioned earlier, the prevention of illness in older persons is crucial, as is early detection and treatment of disabling conditions. Community health nursing programs and/or well-elderly clinics throughout the province would be an important measure in maintaining and even improving the health of older persons, possibly preventing the development of those debilitating conditions that may later lead to the use of costly institutional health resources. Both physical and mental problems could be detected and treated at an early stage through visiting and monitoring by community health nurses. Included in this could be health education and counselling (in groups or individually) for older persons and for their families. Some of the areas that could be covered would be nutrition, foot care, education in the use of medications and the monitoring of the use of medications. For a number of years the local health authorities have provided maternal and child health services. With the increasing numbers of older persons it seems only appropriate and also most practical to extend this service to another high risk group — the elderly.

OPTIONS IN HOUSING

9. Safe and suitable housing is an essential element in a supportive environment for older persons.

The majority prefer to remain in their own homes,

and the Council appreciates the help provided through property tax relief and grants for home improvements for homeowners and grants for renters. Reverse mortgages are another possibility which might be further explored as a way of providing extra income to some older homeowners. Another suggestion is the further development of a special loan or grant program to help relatives of older persons renovate or add to their homes to accommodate an older person.

The Council also appreciates the extensive building of subsidized apartment housing (rental) for older persons. This has been and will continue to be most helpful for lower income older persons who feel they can no longer maintain their own homes or who would like the special security of an apartment complex for seniors. The Council suggests that: 1) the management of such housing could be encouraged in some projects to provide more protective oversight (the development of "sheltered housing"); 2) on occasion housing could be combined with other services (multi-level care) as suggested in our report last year concerning the Forestburg proposal; 3) consideration could be given to helping middle-income older persons develop condominium projects. There are a number of older persons with adequate incomes who own their own homes, but who would like to move into a complex that provides the security of living with other seniors. Ways could be found to help them develop such projects. Such a program would not need to be heavily subsidized since these senior citizens could purchase their own apartments.

APPLIED RESEARCH

10. Research is essential if we are to improve the quality of life for future generations of older persons. We need research into all aspects of aging, but particularly research into the ways of most effectively providing service to older persons and evaluation of these services. The adequate collection of data is also essential if our planning and development is to be based on solid, reliable information. For these reasons, the Council has proposed as its long range priority the development of an Alberta Institute on Aging (see Appendix E).

SUPPORTIVE ISSUES

TRANSPORTATION

11. Transportation services are crucial. The present system of transportation grants through the Department of Transportation to municipalities for the development of special services for the elderly and the handicapped should be made more specific and should be continued after 1985. Municipalities should be asked to declare or report on the use of these grant monies; perhaps a survey could be done to determine how these funds have been used by municipalities.

ASSESSMENT

12. At present, as pointed out in the discussion relating to Priority Recommendation Two, each service has its own assessment process. The assessment generally relates to determining whether or not the older person is eligible for the service, whether he or she "fits in." Present assessment methods do not assess an individual's level of functioning or the minimal level of care needed to keep him as independent as possible. A study has been carried out on the present assessment processes in Alberta[12] and both a workshop in the Alberta Symposium on Aging and the Nursing Home Review Panel report expressed concern over the present assessment processes. Both recommended the development of "regional geriatric assessment and treatment services" or "multi-disciplinary assessment teams in geographical areas."

EXPANDED LODGE PROGRAM

13. The lodge program could expand its concept so that when personal care is needed by some residents it could be provided, and the older person would not have to be moved to a nursing home. This reflects our "new approach"—our belief that to the greatest extent possible, services should be brought to the older person rather than trying to fit him/her into the service. This extended help could be provided through the use of community agencies such as home care or through the addition of staff to the lodge, the cost of which could be at least partially met by the older residents themselves. For example, a homemaker could come in daily to assist those residents who need personal care such as bathing and dressing and

a community health nurse could provide health surveillance.

There is also a need for educational and in-service training programs for lodge staff and for greater recreational, educational and fitness activities for the residents. Residents could and should be asked to provide advice to the Foundation Boards about the management of the lodges.

PALLIATIVE CARE AND SUPPORTS FOR THE BEREAVED

14. There is a need for the development of palliative care services in Alberta, services based both in institutions and connected with home care. Developments in palliative care in Alberta should be encouraged and financially supported. The background paper commissioned by the Council forms Appendix C and documents the need.

The background paper also points out the effect of bereavement in the lives of older persons. Many have to deal with much grief and loss, and their periods of bereavement are often not understood and appropriately supported by younger family members and service-providers. This grieving and bereavement, particularly when not understood and supported properly, can have a major effect on physical health.

There is a need for greater education about loss and bereavement in the lives of the elderly; perhaps Further Education Councils should be asked, through the Department of Advanced Education, to provide courses relating to bereavement and palliative care, particularly for older persons and those working with them.

PROTECTIVE ISSUES

NURSING HOMES AND AUXILIARY HOSPITALS

15. The Report of the Nursing Home Review Panel and earlier reports of the Council have made many recommendations about the need for improvement in nursing home and auxiliary hospital care for older persons. In fact, the recent report of the Panel supports many of the earlier recommendations made by this Council. Both the government and the public must now be well aware of the many concerns about this system, and we believe it best simply to state in this

report that we continue to support our past recommendations.

These essential services (nursing homes and auxiliary hospitals) are caring for very frail, disabled persons who are particularly vulnerable. Many of the staff and administrators are concerned and dedicated persons. They need our help and support and the help and support of the government in order to ensure that this vulnerable segment of our elderly population receives the best possible care.

We would emphasize that there is a need for all institutions to work towards restoration of functioning to the greatest extent possible, to work closely with community services (see Priority Recommendation Two), and for some institutions to develop services such as day care and respite care.

Of particular concern is the need for nursing homes and auxiliary hospitals to care more adequately for older persons with mental dysfunctioning; special units in auxiliary hospitals should be developed for severely disturbed older persons whose behavior is disruptive and disturbing. Consideration could be given to using small special community homes, such as group homes, for the mild to moderately dysfunctioning person.

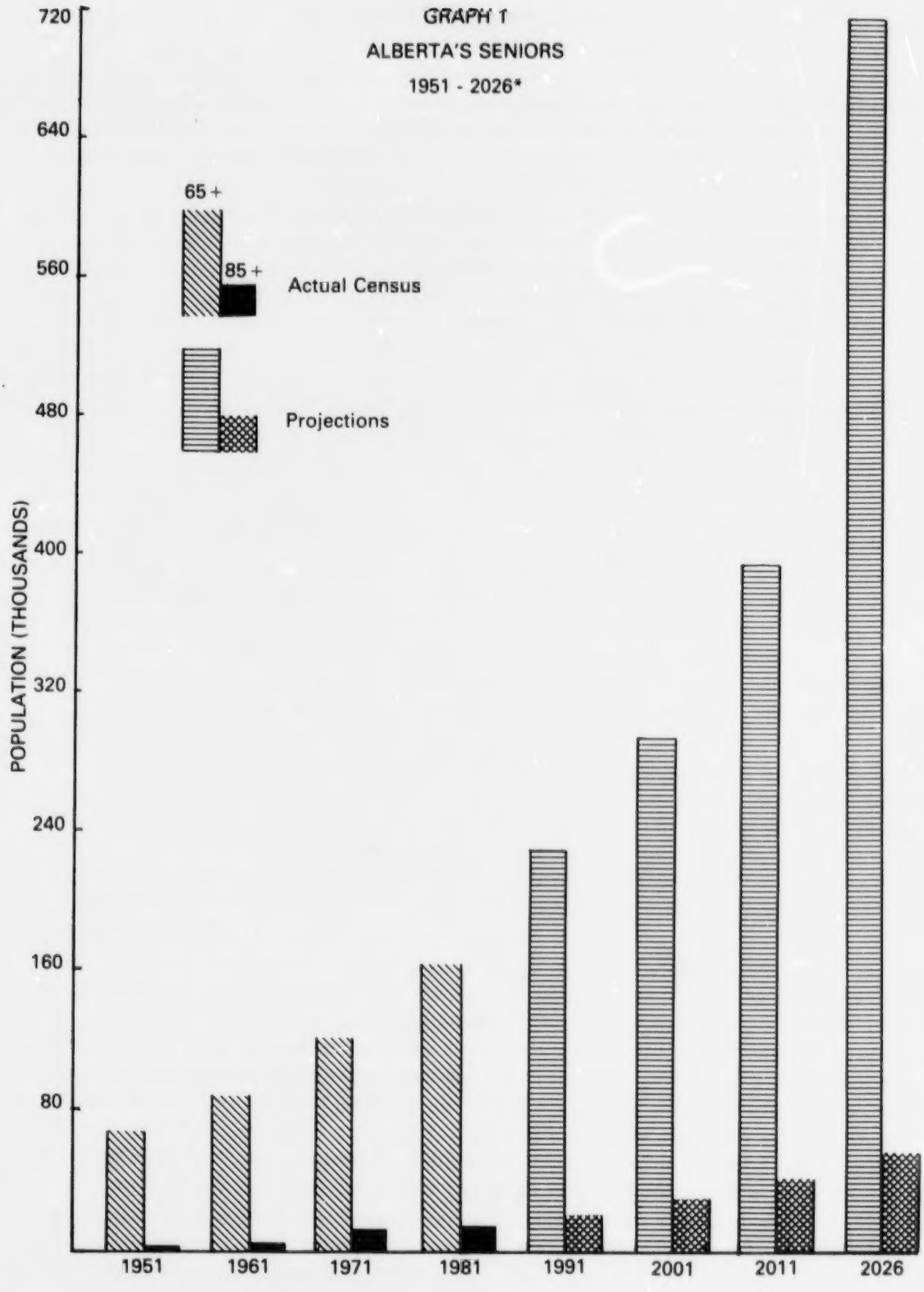
Furthermore, there is a continuing and very great need to find ways to ensure that nursing aides (now mainly untrained and inexperienced) become more knowledgeable and skilled in providing better care to elderly patients.

The Symposium specifically suggested the need for family counselling at the time a person enters an institution with more time for pre-admission arrangements as well as the need for a "team" approach to care.

FOOTNOTES

1. Senior Citizens Bureau, Alberta Social Services and Community Health, Seventh Street Plaza, 10030 – 107 Street, Edmonton, Alberta T5J 3E4
2. Day care is the provision of an organized program of services during the day in a group setting for the purpose of supporting personal independence and promoting social, physical and emotional well-being. The services are designed for persons who are physically, mentally, socially and/or emotionally impaired who need daytime supervision and perhaps some personal care in order to remain in their own homes. Day care provides relief for family members, and social activities for those who are living alone. Its goal is maintenance of functioning. Persons remain in day care over a long period of time. Day hospitals, on the other hand, are health-related programs under the direction of health professionals for persons who require diagnostic, rehabilitative and therapeutic services for a scheduled period of time.
3. The Co-ordinated Home Care program is a health-related home care program funded by the Department of Social Services and Community Health and administered and delivered by 26 of the 27 local health authorities in Alberta. To be eligible, an individual must require a professional health service — nursing, rehabilitation therapy or speech therapy. If one is eligible then additional support services such as homemaker services may be provided. The Council is recommending that the eligibility for this program be expanded so that persons who are frail and disabled can receive support services, such as homemaker services, even if they do not require a health service. It is further recommending that support services be made available in greater quantity and range and that services be available over the weekend.
4. In a recent major research study in Saskatchewan, 15 per cent of the older persons in long-term institutional care **(all levels)** in Saskatchewan were judged to have been capable, when admitted, of living in the community with very little help (Long Term Care of the Elderly, Report of the Saskatchewan Health Status Survey of the Elderly; Part I: The Elderly in Long Term Care, August 1981). It also suggests that lack of support, not ill health or disability, constitutes a major reason for persons entering institutional care.
5. This does not include income support, housing and special benefits such as the Extended Health Benefits and Blue Cross program. It includes expenditures for persons 65+ in active treatment hospitals (an estimate only, based on the total operating expense per patient day, $194.47 in 1979/80), auxiliary hospitals, nursing homes, the two Alberta Hospitals, the Extended Care Centres of the Department of Social Services and Community Health, homes for special care, the Co-ordinated Home Care program, Family and Community Support Services funding for the elderly (not senior centres) community health nursing, regional mental health services, day hospitals, the Public Guardian program and medical services.
6. From the *Report of the North American Regional Technical Meeting on Aging in Preparation for the World Assembly on Aging,* Washington, D.C. The National Council on the Aging, Inc., 1981.

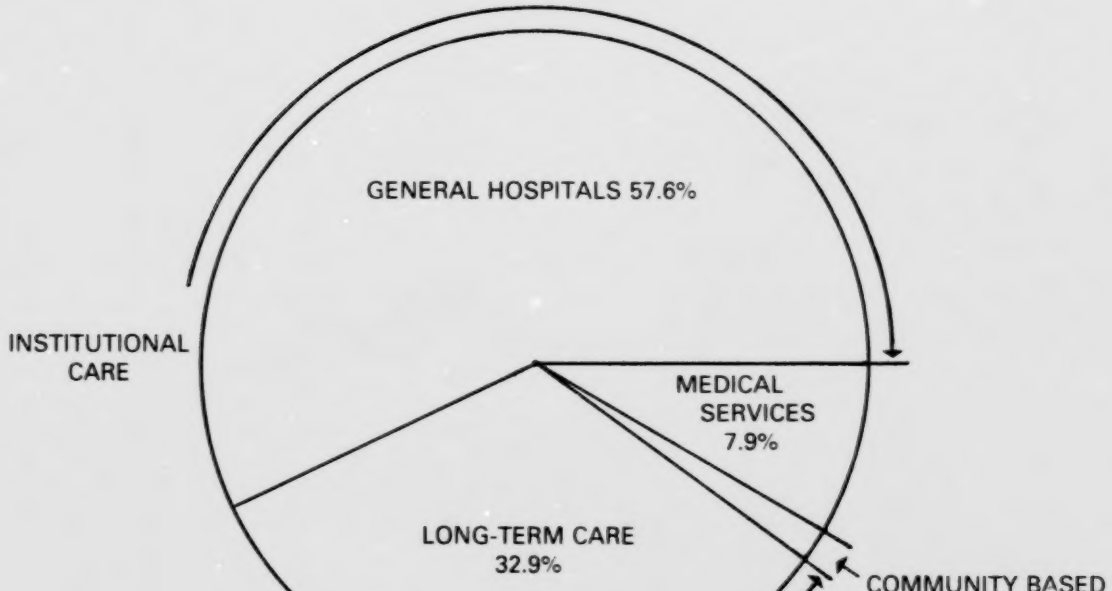
7. Canada, National Health and Welfare, *Manitoba/Canada Home Care Study – An Overview of the Results,* April 1982.
8. The Alberta Association of Registered Nursing Orderlies suggests that considerable cost-savings could be effected by using nursing orderlies to care for elderly patients at home. These elderly patients are waiting now in active treatment hospitals for auxiliary hospital beds (*Edmonton Sun,* October 7, 1982; *Edmonton Journal,* October 22, 1982; *Edmonton Journal,* October 24, 1982).
9. The Saskatchewan study (see footnote 4) suggests that the need for services to "support the supporter," particularly of older persons with dementia, was the greatest unmet need uncovered in the survey of community elderly (1,267 older persons living in various communities throughout the province were surveyed). "Day programs, relief admission programs, support groups, counselling and sitter services to meet the needs of care-givers and stabilize and prolong community placement are unavailable."
10. *Multi-Level Care Facilities – Evaluation of Models for Alberta,* 1982; *Assessment and Placement for Long-Term Care Study,* 1982.
11. Nardone, M., "Characteristics Predicting Community Care for Mentally Ill Older Persons." *The Gerontologist,* Vol. 20, Number 6 (December, 1980) pp. 661 – 668.
12. *Assessment and Placement for Long Term Care Study,* Department of Hospitals and Medical Care, 1982.


GRAPH 1
ALBERTA'S SENIORS
1951 - 2026*
720
640
560
480
400
320
240
160
80
POPULATION (THOUSANDS)
65+
85+
Actual Census
Projections
1951
1961
1971
1981
1991
2001
2011
2026

SOURCE

1951 – 1971:	Statistics Canada, Cat. no. 94-702 Vol. III Part: 1 (Bull. 3.1-2), November 1974.
1981:	Unpublished Advance Information, 1982.
1991 – 2001:	Statistics Canada, Cat. no. 91-520 Occasional, population projections for Canada and the provinces 1976 – 2001, 1979, (Series 2).
2011 – 2026:	Statistics Canada, unpublished personal communication (Series 2).

FIGURE 1
Distribution of 1979/80 Health
and Social Service Expenditures
for Persons 65 + in Alberta



See Footnote 5 (page 22) for explanation of services included.

APPENDIX A

COMMENTS ON THE REPORT OF THE NURSING HOME REVIEW PANEL

Submitted by the Provincial Senior Citizens Advisory Council to the Honourable Bob Bogle, September 9th, 1982

1982 Report,
Provincial Senior
Citizens Advisory
Council

September 9th, 1982

Honourable B. Bogle
Minister, Social Services
and Community Health
424 Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Bogle:

The Council reviewed with appreciation the Nursing Home Review Panel Report. In general Council supports the Report, recognizing that the range of changes recommended will have to be effected on an incremental basis.

The members were pleased to see confirmed many of the recommendations and points emphasized in their own reports as well those contained in other briefs and letters from concerned organizations. It is interesting to note that many of these same points were recorded at the recent Alberta Symposium on Aging and more recently made in the Action Report at the United Nations World Assembly on Aging in Vienna.

The Council believes our policies to date regarding the funding for and the delivery of institutional services have tolerated and indirectly encouraged indifference on the part of younger family members. The Report recommends changes which, in addition to improving care in our institutions, would strengthen our community services and therefore the family life of older persons. As Elaine Brody, a keynote speaker at the Alberta Symposium on Aging, said, "the path to strengthening personal support systems lies in strengthening formal supports".

Believing that you and your Ministerial colleagues will also generally support the recommendations in the Report and wish to see some change effected, we are submitting the following specific comments and suggestions.

1. The recommendations relate primarily to the Departments of Hospitals and Medical Care, Social Services and Community Health and to a lesser degree Housing and Public Works. In order for these recommendations to be enacted the two major departments must act. They must agree upon what should be done first (the incremental implementations) and who should do what, and when.

We recommend that the Report be referred to the Health Care and Social Services Planning Committee (Joint Planning Committee) which consists of the deputy ministers of both departments. The Joint Planning Committee should decide on the most effective order of implementation, the time lines for implementation, and give the authority to appropriate staff to act.

2. We strongly support the Report's recommendation to expand home care. In addition to the arguments presented by the Review Panel in Recommendation #39, statistical results are now available from the Manitoba experience and discussed in the Report, *Manitoba/ Canada Home Care Study – An Overview of the Results.* This report shows that a comprehensive home care program with equal emphasis on health and social services can result in a major cost-saving in care for the elderly. The amount saved by the Manitoba

Home Care program was roughly one million dollars a month for the 1,167 persons in this study. What is even more striking is that the study was restricted to the highest cost period, that is, the first month of service for those served.

This means that an expanded home care program, while it would serve persons who would otherwise not receive any service, more than compensates for this by the large amounts saved in keeping others out of costly institutions.

If we look at the Alberta scene we find that the Co-ordinated Home Care program, while more costly per patient than the Manitoba program because it has a medical entry point, still cost less per patient in public funds than care in nursing homes and auxiliary hospitals in 1979/80. In that year, the Co-ordinated Home Care program (including direct service and administrative costs) was $370.42 a month per patient discharged; Nursing Home Care, $622.50 per month per patient; Auxiliary Hospital Care, average $1,604.40 per month per patient.

It is recognized that there are persons who will need care in nursing homes and auxiliary hospitals regardless of what community services are available. However, the Council is convinced that a more comprehensive (social as well as medical entry) and expanded (7 days a week) home care program as recommended by the Panel could serve many of those now going into institutional care and could result in cost savings. Most importantly it would support a more independent and normal lifestyle for those elderly persons affected.

3. We recommend that consideration be given to combining the functions described in the Report's recommendations 3, 4 and 26 and that these functions become the "co-ordinated system of care" recommended in the Report's recommendation 25, and placed under one governing body in each geographical area of service.

The combined functions would include a patient classification system (Recommendation 3) a travelling rehabilitation team (Recommendation 4) and a multidisciplinary assessment team (Recommendation 26).

We suggest that this be tried on a pilot project basis in one or two interested regions and evaluated before implemented on any large scale.

The assessment referred to, which would link together assessment for both community and institutional services, should have a diagnostic, treatment and rehabilitation capability. In other words, the assessment should not be only to determine where the person "fits in" but should involve a thorough examination of the older person's needs and functioning and the development of a plan for care which, if necessary, would involve treatment and rehabilitation.

Sincerely yours,

Duncan Rogers
Chairman, Provincial Senior
Citizens Advisory Council

DR/ba

APPENDIX B

HUMAN RIGHTS AND OLDER PERSONS

**A Discussion Paper Prepared for
the Provincial Senior Citizens
Advisory Council 1982
Report to the Minister of
Social Services and Community Health**

Nan McBlane

1982 Report
Provincial Senior
Citizens Advisory
Council

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APPENDICES*

Appendix A United Nations Universal Declaration of Human Rights

Appendix B Summary Canadian Charter of Rights and Freedoms

Appendix C Summary Canadian Bill of Rights, Canadian Human Rights Act, Alberta Bill of Rights, Alberta Individual's Rights Protection Act

Appendix D A Comparison of the Protection Offered by Provincial Human Rights Legislation in Canada

* These are available from the Senior Citizens Bureau, Alberta Social Services and Community Health, 10030 – 107 Street, Edmonton, Alberta T5J 3E4.

INTRODUCTION

The Canadian Charter of Rights and Freedoms adopted in 1982 adds a new dimension to the issues concerning rights for older persons. It states in the Section on equality rights (Section 15) that age is a prohibited basis for discrimination. This equality section will come into effect in Alberta unless the provincial legislature decides to "opt out" of it. What does this mean and how may it affect older Albertans within the broad context of human rights?

This paper is a beginning and exploratory attempt to sensitize the public to issues concerning the rights of older persons and the way in which discrimination on the basis of age may affect those rights. It will include a look at the United Nations Universal Declaration of Human Rights. It will examine Canadian federal and provincial legislation concerning rights and the protection provided against forms of age discrimination, particularly as these acts affect senior citizens in Alberta. It will also discuss the discriminatory social practices and social environment that may compromise the rights of older persons and conclude with a look at the future and some recommendations.

WHAT IS DISCRIMINATION?

Discrimination is defined as "the act of making a difference in favour of or against."[1] Age-based discrimination exists when this act is made on the basis of age alone. For the purpose of this paper we are using the word discrimination to refer to negative forms of social practice which may affect the rights of persons who are age 65 and over.

There are a number of discriminatory practices which the elderly[2] face because of their age alone. There are other forms of discrimination, which are not based only on age, but which have a particularly devastating impact on them. It is obvious that many of these discriminatory practices are based not so much on blatant prejudice but rather on a lack of understanding of aging and the aged, and stereotyping, that is, seeing all persons in the later years as having common characteristics.

RIGHTS AND LEGISLATION

There are a number of pieces of legislation which deal with or affect rights. The United Nations Universal Declaration of Human Rights, while not legislation, defines human rights which are generally considered to be important for all individuals. Several Canadian acts, most importantly the recent Charter of Rights and Freedoms, spell out the rights of Canadians and protection provided for those who may face discrimination. This section presents some highlights from the Declaration and the Canadian legislation and discusses the impact of these on the elderly.

United Nations Universal Declaration of Human Rights

The United Nations Universal Declaration of Human Rights was adopted by the General Assembly in December 1948 and signed by Canada. This Declaration (see Appendix A) declares that "all human beings are born free and equal in dignity and rights." It includes many of the rights common in Anglo-Saxon law such as the "right to life, liberty and the

security of person," "the right to own property alone as well as in association with others," and states "all are equal before the law." It also contains human rights such as the right to "work," the right of "equal pay for equal work," the right to a "standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care, and necessary social services...," the right to "education," and the right to "participate freely in cultural life of the community."

The Declaration in Article 2, which states that "everyone is entitled to these rights and freedoms....without distinction of **any kind**," then goes on to list examples of the kinds of "distinction" that are prohibited: "such as race, colour, sex...." Age is not one of the distinctions listed.

However, in 1982, the United Nations World Assembly on Aging developed an International Plan of Action on Aging to be ratified by the General Assembly. In its Preamble it states:

> The countries gathered in the World Assembly on Aging....do solemnly reaffirm their belief that the fundamental and inalienable rights enshrined in the Universal Declaration of Human Rights apply fully and undiminishedly to the aging....

While this has no legal effect in Canada, it does have symbolic effect. It is a strong statement by a world body, in which Canada had a role, supporting the principle that the aging have "rights" (the ones declared in the United Nations document) and that they are entitled to them without distinction made on the basis of their age.

Canadian Charter of Rights and Freedoms

The Canadian Charter of Rights and Freedoms, the legislation that prompts this paper, was adopted in 1982 and is to take precedence over all other human rights legislation in Canada especially where sections of the existing acts are contrary to the Charter. The purpose of the Charter (see Appendix B) is to codify and guarantee the rights and freedoms of individuals in Canada "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society" (Section 1).

The Charter covers fundamental freedoms such as freedom of conscience and religion and freedom of expression; it covers mobility, democratic, legal and language rights, and a few other areas, and provides for equality rights and affirmative action programs. It does not include many of the human rights, such as the right to work, listed in the United Nations Declaration. Of particular importance to this paper are Section 7 and Section 15. In Section 7, personal liberty and security and the right to life are protected, and a person may not be deprived of these rights without legal reasons and unless the deprivation has been approved by a court of law. Section 15(1) states: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." No definition of age is given. Subsection 2 of this Section declares that affirmative action programs used to assist economically and socially disadvantaged groups are not discriminatory.

Section 15 (the equality rights) of the Charter does not come into effect until April 17, 1985, and after that Section 33 allows Parliament or any legislature to "opt out" of it as well as the sections dealing with basic freedoms and legal rights. This "opting out" ceases to have effect five years after it comes into force and must be re-enacted if its continuation is desired.

Therefore, as it stands now in 1982, the elderly in Alberta (like all individuals in Alberta) are guaranteed certain freedoms and rights by the Charter but it does not protect them against age-based discrimination for the equality section will not be in effect until 1985. In the section, "The Future," we will discuss the implications of this.

Earlier Federal Rights Legislation

There are two previous federal acts which deal with rights and the protection of rights — the Canadian Bill of Rights, 1960, and the Canadian Human Rights Act, 1978 (see Appendix C). They have almost no bearing on the lives of older Albertans as they both relate only to persons within the jurisdiction of the Canadian Parliament — primarily federal employees. The Bill of Rights guarantees certain freedoms without discrimination on the basis of a number of factors, and age is not listed among these factors. The Canadian Human Rights Act forbids discrimination concerning access to goods, services, facilities and accommodation on the basis of a number of factors, and in this case age, not defined, is mentioned. However, this Act (which established the Canadian Human Rights Commission) expressly permits mandatory retirement on the basis of age, stating it is not discriminatory to force people to retire if that is the "normal" age of retirement for that job.

So while these federal acts have little or no bearing on the lives of persons 65 and over in Alberta, they both may have some negative symbolic effect. The Bill of Rights does not list "age" as a prohibited ground of discrimination, and the Human Rights Act provides legislated support for one practice of age-based discrimination, mandatory retirement, for federal employees.

Alberta Rights Legislation

The province of Alberta has two pieces of legislation concerning rights — the Alberta Bill of Rights, 1973, and the Alberta Individual's Rights Protection Act, 1973. They apply to everyone living in the province, except those within the jurisdiction of the above federal acts.

The Bill of Rights (see Appendix C) guarantees certain basic rights and freedoms (such as freedom of religion and speech, the enjoyment of property and equality before the law). It provides that no one shall be discriminated against on the basis of a number of factors, but age is not one of the factors mentioned. The Individual's Rights Protection Act (see Appendix C) recognizes that all persons are equal in dignity and rights without regard to race, religious beliefs, colour, sex, physical characteristics, age, ancestry or place of origin. However, while it forbids discrimination in a number of specific areas on the basis of a number of these factors, it forbids discrimination on the basis of age only in employment and the displaying of signs. Furthermore, in Section 38(a) age is defined as "any age of 45 years or more and less than 65 years." Therefore, persons 65 and over in Alberta are not protected against age-based discrimination by either of these two acts.

There is one further piece of legislation in Alberta which does affect the rights of older persons. It is the Alberta Dependent Adults Act, but because it does not relate to age-based discrimination, it is not discussed in any detail in this paper. We are including it only because it does have the capacity to remove the rights of persons, and there are a number of older persons who have been or may be affected by it.

The Act, which was passed in 1976, provides for the protection of persons 18 and over who, on a temporary or long-term basis, are unable to attend to their personal or business

affairs. By providing a guardian and/or trustee to look after their interests, the Act protects that small group of seniors who are suffering from mental confusion and who may therefore be vulnerable to neglect and abuse. It also provides for the issuing of compulsory care orders, so that persons who may be dangerous to themselves or to society may be legally confined by care-givers. The Act protects persons, but it can also deprive persons of their personal liberty — one of their basic rights. One danger in the administration of the Act lies in the difficulty of determining incompetency, that is, the inability to handle personal and business affairs, in older persons. Mental confusion may be temporary and caused by reversible conditions. It is, therefore, essential that the system of checks and balances and procedures for review work effectively, so that persons are not deprived of their rights unnecessarily.

Provincial Rights Legislation and Comparisons

All other provinces in Canada have human rights acts among their statutes which have provisions similar to the Canadian Human Rights Act, and many of the acts cite the Universal Declaration of Human Rights (United Nations) as the basis for their legislation.

The prohibited grounds of discrimination and the protected aspects vary from province to province. Appendix D outlines the provisions in various provincial acts.

In all provinces except Quebec (where age is not mentioned except in Section 48, see below), persons are protected on the basis of age in the area of employment, and in a number of provinces this age protection is extended to other areas, for example, conditions of contracts, sale of land and commercial property, harassment, access to facilities, rent of dwelling units or commercial units. In no province is age a prohibited ground against discrimination in access to educational facilities.

Section 48 of the Quebec Charter of Rights and Freedoms would seem to offer special protection to older persons. It states "every aged person and every handicapped person has a right to protection against any form of exploitation." Exactly what protection this clause offers is not clarified.

Definitions of age vary among the provinces. Quebec and Manitoba give no definition of age. New Brunswick defines age as 19 and over. Ontario defines it as 18 and over but in the area of employment only protects people from 18 to 64 years, inclusive. Ages 18 to 65, inclusive, are protected in Saskatchewan, Prince Edward Island and Nova Scotia, and ages 19 to 65 are protected in Newfoundland. Alberta and British Columbia protect only the group from age 45 to 64, inclusive.

It should be remembered, however, that the areas which are covered by age-based protection vary greatly (see Appendix D). From this it can be seen that several of the human rights statutes in other provinces offer broader protection than Alberta's act, but that in general protection against age-based discrimination is neither particularly good nor is it uniform across Canada.

DISCRIMINATORY SOCIAL PRACTICES

The Canadian federal and provincial legislation and the United Nations documents spell out certain rights. However, the ability of older persons to attain some of these rights is limited by discriminatory social practices which are based on attitudes and beliefs about

the elderly, lack of knowledge about the aging process and stereotyping of the elderly. These beliefs and attitudes are also the basis of some of the age-related benefits we provide to persons 65 and over. For example, the Alberta government provides a variety of health and housing benefits to persons 65 and over (and their dependents) on the basis of chronological age only — not on the basis of need. Examples of some of these benefits are property tax rebates, renters' grants and extended health benefits.

Current retirement practices in Canada and Alberta are a form of discrimination, based on age alone, which affect a person's right to a lifestyle he/she chooses, to work, and to an adequate standard of living.

By the time Albertans reach the age of 65 years they are, by custom, normally retired from the labor force. In 1976 only about 16 per cent of persons 65 and over were employed in Alberta, and most of these were self-employed farmers (Engelmann and Stevenson, 1980).

It should be noted that the compulsion to retire at 60 or 65 years of age in Canada is caused by societal customs (including employer and union practices) not by statute (O'Sullivan, 1980). Much of the custom is tied to the economic situation at any given time and to the number of young people available to the labor force. Society views it as being less of an evil to have seniors retired (unemployed) than to have younger persons unemployed (Kreps, 1980; Johnson and Williamson, 1980; Allentuck, 1977). It is also less expensive for an employer to pay younger less experienced workers than to pay senior personnel (Allentuck, 1977).

Attitudes towards retirement vary from person-to-person and across occupations. For some people it is a reward for a life of drudgery; for others it is a form of banishment from society just as they reach the peak of their careers (Kreps, ed., 1962).

However, retirement generally reduces a person's income, and there are few opportunities to significantly increase this income. Some persons are always able to find work (particularly the self-employed) but generally, once a person has retired, it is difficult to find other comparable employment. Available jobs tend to be those which are low skill and low-paying such as janitorial or security guard work. Highly-skilled retirees such as accountants, managers and engineers may prefer to continue to use the knowledge they have gained over the years and are therefore not interested in janitorial work nor in being security guards (Society for the Retired, 1982).

The result may be an income which does not meet even the material needs of an older person. More importantly the result may be low morale, feelings of low self-worth and depression for retirement labels people as dependent (Beattie, 1982). Society also loses in that it does not take advantage of the skills and talents of the retirees, the majority of whom are still healthy and active. Since adequate income and good health are seen by most of the studies as being the keys to enjoying retirement, the process of mandatory retirement can be a vicious circle for some older people.

Lack of adequate incomes which keep pace with inflation may affect the ability of older persons to find decent, but increasingly costly, rental housing or even to maintain a home. Sometimes housing is designed in such a way that it is not easily accessible to older persons who have some disability. Both the cost of housing and its inadequate design do not, of course discriminate against just the elderly. However, they do affect many older persons' choices in housing for among the elderly we find a fairly high number of persons with lower incomes and disabilities.

Theoretically there is no discrimination against seniors in the field of education, and older persons are in a way encouraged through the waiver of tuition fees to attend universities and community colleges. However, there is a general discouragement of their participation in some professional faculties. For example, quota faculties such as law, medicine and commerce may permit older persons to apply, but the candidate screening process may screen them out. There is considerable societal pressure to give preference in professional faculties such as these to younger students.

Some concern has been raised about the lack of protection for seniors against discrimination based on age in the granting of credit. In the United States the Equal Credit Opportunity Act states that no one can be denied a loan on the basis of race, color, religion, national origin, sex, marital status or age. As further protection to seniors it spells out that credit cannot be denied because of inability to get life insurance and also says that retirement income cannot be discounted in a credit situation. There seems to be no similar kind of protection for older people in Canada.

The right to adequate medical care is listed as an item in the Universal Declaration of Human Rights. Many who work with older persons and much of the literature confirms that this right is often denied to them and that the elderly suffer from a form of age-based discrimination in health care practice, discrimination which is not blatant and intentional as much as it is based on stereotyping and on the lack of specific knowlege about aging and the elderly.

Older persons may have difficulty obtaining adequate health care because health personnel (Butler, 1975; Lenzer, 1978; Peto, 1982) fail to differentiate between the process of aging and ill health, and ill health is seen as a natural part of aging, not something that needs medical intervention.

Some health care personnel are not particularly interested in working with older persons. Stephens (Stephens, 1979) discusses three reasons for doctors not wanting to treat elderly patients: (1) the field is depressing, difficult...not challenging and frequently unpleasant; (2) there is inadequate knowledge about chronic illnesses; (3) doctors suffer from a fear of aging (gerontophobia) themselves. Gerontophobia manifests itself in a doctor being cold and business-like or paternalistic with an elderly patient.

Lack of knowledge about chronic illness may also affect the care older persons receive. Lenzer (1978) discusses the lack of knowledge about chronic diseases and conditions in terms of the historical growth of the medical profession. Medicine has always been oriented towards crises such as contagious diseases, injuries and surgeries which must be attended to immediately and then the patient is "cured." Long-term chronic illnesses tend to be phenomena mostly of the twentieth century (Carson, 1962) as is the increasing size of the older population (Stone and Marceau, 1977). Because many older persons suffer from chronic disease, they then are affected by this approach to illness.

They are also often over-medicated due to a lack of knowledge about the effect of various medications on older persons. The basis for this lack of knowledge is related to a lack of training in the specifics of prescribing drugs for the elderly which again is related to a general lack of interest (age-based discrimination) in working with seniors (Butler, 1975).[3]

Some persons have expressed a fear that a perceived shortage of health care resources may also discriminate against older persons, in that a few health care personnel may believe that these resources should be reserved for the young (Wallace, 1982).[4]

THE FUTURE

What will be the future concerning age-based discriminatory practices in Alberta? What do we want the future to be? These questions become even more relevant with the advent of the Canadian Charter of Rights and Freedoms, which states in Section 15(1):

> Every individual is equal before and under the law and has the right to equal benefit of the law without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

These words have symbolic meaning and, as the Canadian Human Rights Commission states in its 1981 Annual Report, "the Charter has strengthened human rights commissions by reaffirming Canada's commitment to the basic principles of fairness, justice and equality. We expect people to be more aware of their rights, more active in seeking to exercise them" (Canadian Human Rights Commission, 1982).

In addition to the recognition the Charter may be giving to age rights, the Canadian Human Rights Commission is also asking for more protection of the rights of older persons. It is asking Parliament to remove the restriction on the protection against discrimination based on age in the Canadian Human Rights Act, stating:

> An exception in the Act makes it nondiscriminatory to impose mandatory retirement on the basis of age so long as the age chosen is 'normal' for the type of job. Human rights principles suggest that the ability to do the job, not age, should determine the point at which a person may be compelled to retire. It should be noted that this amendment is not intended to have any consequences for voluntary early retirement (Canadian Human Rights Commission, 1982).

The increasing number and proportion of older persons in our population is another factor that may affect the future of age-based discrimination. Projections for the next thirty to fifty years indicate that the number of elderly will continue to increase at an increasing rate to the second and third decades of the twenty-first century. The proportion of younger persons in the population and in the labour force will decrease to the 2030's (Stone and Marceau, 1977; Allentuck, 1977; Denton and Spencer, 1980; Stone and Fletcher, 1980 and 1981). By 2030 one in five persons in Canada may be over 65 years of age, compared with one in ten in 1979. In addition, for every three persons between 20 and 64 years of age (roughly the labour force), there may be one senior citizen. The present ratio is seven to one (The Economic Council of Canada, 1979).

The projected changes in the population structure may result in an older population that becomes more vocal and assertive about its rights; in particular the right to work may be supported by those seniors who do not wish to retire or cannot afford to retire. Younger workers may exert some pressure to change mandatory retirement practices if they are heavily taxed to support older persons (Stone and Marceau, 1977; Denton and Spencer, 1980; Allentuck, 1977). The United States, because of concerns over financing Social Security payments, abolished mandatory retirement for federal civil servants in 1979 and raised the age for retirement in private industry to 70 years of age from 65 years of age. There is now legislation before Congress to abolish any age for compulsory retirement (Beattie, 1982).

Some of the decisions made recently concerning mandatory retirement policies which have been challenged may influence judgements made regarding the equality rights pro-

visions of the Charter and/or may influence provincial legislation. For example, in Manitoba where the Human Rights Act does not define age, a university professor was reinstated after challenging the university's policy regarding mandatory retirement.[5] In New Brunswick, where the Human Rights Act defines age as "19 years of age or over", a crane operator was reinstated, at his seniority level and awarded back pay, after he protested his enforced retirement at 65 years of age.[6] It is interesting to note that a tribunal, ruling on a case brought before it by the Canadian Human Rights Commission, has just stated that a particular individual cannot be forced to retire at age 65 because the company could not prove that it had any set age specified as the age for retirement (the Canadian Human Rights Act now permits retirement if there is a stated age for normal retirement for the position). This tribunal decision is now being appealed by the company.[7]

These decisions all point in the direction of an increasing recognition of the discrimination inherent in our present practices concerning mandatory retirement and show a movement towards change. As we mentioned earlier, three provinces now define age very broadly, providing some protection for those 65 and over and providing this protection not only in the field of employment but in other areas as well as access to residential accommodation. Perhaps in time legislative protection against age-based discrimination will be extended to other areas such as credit. In addition, older people may become more aware of their rights and advocate for them whether these rights pertain to employment, to health care, to housing or to other areas of concern.

It would seem important to develop an increasing awareness on the part of older individuals, and the groups of which they are a part, of fairness and fair treatment for seniors. This could have an effect on legislation and judicial interpretation of legislation as well as practices in society.

While legislation and advocacy are most important in the short to medium term, in the long term the key to protecting the status of the aged is the societal practices which reflect people's attitudes. The key to changing these attitudes and therefore the key to eliminating discrimination is education (Fairweather, 1978). Only through understanding the process of aging can we guarantee that all persons will have equal access to protection of their human and civil rights. An important part of this process is based on older people being aware of needed changes. Lastly, while we are concerned about ways in which the rights of the elderly may be adversely affected in the future because of age-based discrimination, we want to emphasize also that seniors, like persons of all ages in society, have responsibilities. With the exercise of every right or freedom goes a responsibility to do so in a way that does not limit the rights of others, that does not interfere with others, and, we would add, contributes to the common good—the well-being of others and society.

The parameters of rights are well-stated in the United Nations Universal Declaration of Human Rights (Article 29):

> Everyone has duties to the community in which alone the free and full development of his personality is possible.
> In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

CONCLUSIONS

Through a review of the legislation and an examination of discriminatory social practices, this paper has attempted to sensitize the reader to issues concerning the rights of older persons.

The issues raised indicate that several approaches could be undertaken to effect change. These appear to be very similar to the thrusts from the recent Symposium on Aging.

1. There is an obvious need for more education about aging and older people to counteract the lack of knowledge and stereotyping that is the basis of many of our present discriminatory practices.
2. There may be a need for a Seniors' Advocate to ensure greater attention is paid to the rights of the elderly.
3. The Province of Alberta could change the Individual's Rights Protection Act to bring it more into line with the equality section of the new Charter which will come into effect in 1985. It could broaden the definition of age, stating just "age" with no limitations as the Charter does, or it could define age as 18 and over. It could cover a number of other areas not now protected (persons are now protected only in employment and the displaying of signs and notices) such as access to public facilities, services, accommodations, to the renting of commercial or dwelling units and to obtaining credit. Changes to our own legislation might be the most immediate and effective way of increasing protection for older Albertans against age-based discrimination.

RECOMMENDATION

THE COUNCIL RECOMMENDS THAT THE INDIVIDUAL'S RIGHTS PROTECTION ACT BE AMENDED BY CHANGING THE DEFINITION OF THE PROTECTED AGE, WHICH IS NOW AGED 45 TO 64 INCLUSIVE, TO AGE 18 AND OVER. FURTHERMORE, CONSIDERATION SHOULD BE GIVEN TO INCLUDING OTHER AREAS NOT NOW PROTECTED.

FOOTNOTES

1. *Dictionary of Canadian English: The Senior Dictionary.* Toronto: Gage Education Publishing Limited. 1973 p. 332.
2. The terms "the elderly," "senior citizens," "older persons," "the aging" and "the aged" are used interchangeably to refer to persons 65+.
3. Dr. R.L. Ecuyer in his presentation on November 5, 1982 at the Canadian Association on Gerontology meeting in Winnipeg said most health professionals tend to feel that old people are going to die anyway so why bother to do anything.
4. The "right to life" clause in the Charter of Rights and Freedoms may become more important for older persons.
5. *McIntire* v *University of Manitoba* case (1981) 1 W.W.R. 696 C.A. (1980) 6 W.W.R. 440 Q.B.
6. *Little* v *Saint Johns Shipbuilding and Drydock Company* in O'Sullivan, 1980.
7. Decision rendered on August 24, 1982, *Prior* v *Canadian National Railway Company.*

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APPENDIX C

DEATH, DYING AND THE ELDERLY

**A Discussion Paper Prepared for
the Provincial Senior Citizens
Advisory Council 1982
Report to the Minister of
Social Services and Community Health**

Sandra M. Deane

1982 Report
Provincial Senior
Citizens Advisory
Council

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Appendix I Definition, Organization and Components of Palliative Care

Appendix II Examples of Existing Services in Alberta

Appendix III Interviews Carried Out

The appendices are available from the Senior Citizens Bureau, Alberta Social Services and Community Health, 10030 – 107 Street, Edmonton, Alberta T5J 3E4.

I INTRODUCTION

Facing a death, whether that of a family member, friend or one's own, is one of the greatest stresses of life and one that must be faced by each individual. Yet until recently death was a taboo subject for discussion. Historically, when death came it was swift, caused by acute, infectious disease and two-thirds of deaths occurred under the age of 15. In today's society two-thirds of deaths occur over the age of 65 and one can be 'in a state of dying' long enough for that period to be problematic (Lofland, 1978).

However, it is interesting to note that until quite recently:

(1) Much of the literature on death and dying did not discuss the elderly, and conversely the aging literature contained little on death and dying.

(2) The majority of research is in connection with those who have been defined as 'terminally ill'.

Dying is a social passage and what happens to patients defined as dying is affected by the actions and choices of those around them. Often these actions isolate the dying because care-givers, family and friends find it difficult to deal with death. Afraid of doing or saying the wrong thing, they do or say nothing.

The elderly who are dying face a 'double whammy.' There are many negative attitudes and beliefs towards aging and the aged generally in our society which are not necessarily true but affect the way in which the aged are treated. This combines with the fear of death and the dying to present problems for the aged. The death of an elderly person is often considered less tragic than the death of a younger person. Because we do not always value the aged, the social value of their remaining life is diminished and minimum physical care is all that is considered necessary. Kalish (1981) notes:

> The terminally aged may be as helpless as a child, but they seldom arouse tenderness.

An important question to be considered is the definition of 'terminally ill'. Is someone aged 85, frail and suffering from one or two chronic diseases "in a state of dying"? Certainly the knowledge that death is approaching is ever present but do theories of death and dying apply in these cases? This paper will attempt briefly to explore this question.

Even when defined as 'terminally ill', patients can experience partial or total remission and live much longer than the original prognosis suggested. Equally, the frail elderly should not be treated as if they were terminally ill. Therefore, it is important that the care and services we provide should emphasize the quality of life and not focus on death.

> We cannot give death with dignity, but we can help create conditions in which an individual can live with dignity until death. (Kalish, 1981)

For many people death and bereavement have negative connotations but by caring for the dying individual, many fears can be allayed; helping the bereaved can lead to a growth experience.

The first section of this paper will discuss some of the theories of death, dying and bereavement emphasizing the aspects most applicable to the aged.

Secondly, based on the literature review and interviews with professionals in the field, the type of care and services that best meet the needs of the dying, bereaved and frail elderly will be proposed, including reference to palliative care.

A brief survey of services in place or being planned in the Province of Alberta will be given; gaps and problems will be identified. Finally, conclusions drawn and recommendations for policy or improvement will be specified.

For purposes of this paper "old," "aged," "older person" and "elderly" will be used interchangeably as referring to those 65 and over.

II THEORIES OF DEATH, DYING AND BEREAVEMENT

A. Death and Dying

Although there are several theories put forward on death and dying, further research is required especially in connection with the aged. Death in old age is considered an expected and natural event and perhaps, therefore, it was felt that nothing need be done in this area, particularly as studies have shown a low incidence of death fear amongst the elderly. Life experience does increase coping capacity but when facing death many other factors play an important role, perhaps the most important one being the support systems available. Because of their reduced resources and dwindling friends and family, the elderly can be at increased vulnerability in dealing with stressful situations.

One theory resulted from a look at the elderly in institutions by Gustafson (1972, in Kart 1981) who used the notion of career timetables in connection with nursing home settings. Her view of the final stage of life is a career moving in related, regressive stages towards death. The "benchmarks" or significant events defining the stages for the elderly include the amount of deterioration indicated by social activity, mobility, physical and mental functioning. To achieve a 'successful' career, therefore, it is necessary to have the slowest possible regression from one stage to another.

One of the most important aspects Gustafson identifies is bargaining with the nursing home staff and God to slow the regression towards death. The dying process is not seen as an unbroken line leading to death, but as consisting of a social stage and a terminal stage. During the social stage the patient fights against society (staff, family, peers) imposing a premature social death. At the terminal stage, the signs of death cannot be avoided and the bargaining is carried out directly with God to secure additional time.

Gustafson suggests that if professional staff view the dying process in this way, the dying career would be made less difficult, the social stage could be extended as long as possible and increased support could be given during the terminal stage.

Weisman & Kastenbaum (1968, in Kart 1981) collected medical, social and psychiatric information on patients in a geriatric hospital and identified four stages: prehospital situation, hospital course, preterminal period and final illness. They looked at the circumstances leading to hospitalization, institutional adjustment, relationships and the medical, social and psychiatric events preceeding the terminal illness. The most intensive study centered on the preterminal period and they found patients could be divided into two groups according to their response to imminent death. One group accepted and were

aware of their impending death, but withdrew and did not participate in their regular activities. The second group were highly involved in daily activities and relationships and even began new ones. Fear of dying occurred rarely and usually in the more gravely impaired patients. Perhaps the most well known of the theories is that put forward by Elisabeth-Kubler-Ross (1969); it is based on interviews with terminally ill patients. This theory has become the basis for many seminars and workshops, both for health care professionals and the public. It is important to remember that not all the dying will go through all the stages; some may present two or three simultaneously or experience them in a different order. Kubler-Ross pointed out that family and friends could also experience these stages.

(1) **Denial and Isolation** – the patient may be convinced that the diagnosis is erroneous, that test results have been mixed up and will shop around for further opinions.

(2) **Anger and Resentment** – these emotions can be displaced and projected on to those around and is the most difficult for staff and families to deal with.

(3) **Bargaining** – usually the bargains are made with God, requesting removal of pain and extension of life.

(4) **Depression** – the patient has feelings of loss both reactive regarding past losses and anticipatory regarding what is to come. This stage prepares the patient for the loss of all love objects.

(5) **Acceptance** – this should not be mistaken for happiness or capitulation. The patient can accept death without joy or giving up his remaining life and often the dying individual will "contemplate his coming end with a certain degree of quiet expectation".

(Kubler-Ross, 1969)

The elderly, like the younger groups, are not homogeneous and there is a variation in the way they face death. It has been suggested that while the fear of death itself is low, they still have the fears and needs connected with the process of dying that occur across all ages (Marshall, 1975).

(1) The fear of isolation and abandonment. If the elderly feel that those around them, professionals and family, are withdrawing from them in preparation for death, they can become preoccupied with themselves and have decreased responsiveness; the likelihood of disorientation is increased and they relinquish their will to live.

(2) The fear of pain, progressive deterioration and immobilization is often more ominous than the thought of death itself. From this follows the fear of dependency and that they will no longer have control over their lives.

(3) Anticipation of pain. Although the patient may not be feeling pain, he/she may have known someone who died slowly and painfully. This anticipation of pain is pain itself and can be problematic.

(4) There is a need to review life and to seek the meaning of their life.

B. Bereavement

As with aging and death, society conspires to conceal grief. Those mourning are advised to keep busy, not dwell on the death and friends avoid mentioning the deceased.

In his book, *Bereavement* (1974), Colin Murray Parkes suggests that "mourning is seen as self-indulgent and reprehensible rather than a normal, psychological need." Today there are no set mourning periods or social mourning; many rituals such as the wearing of black are no longer followed and the bereaved person is expected to return to a normal life in a brief time.

It has only recently been recognized that the resolution of grief and loss can take up to two years. Failure to cope with death and the resulting loss can lead to emotional maladaptation. Lindemann (1944) has suggested that it is the failure to mourn appropriately that often precipitates neurotic reactions. As an example, a widow, who had nursed her husband through a long illness and had dealt with the loss very well, began to have problems. Upon investigation it was found that she was actually mourning for her mother who had died 20 years before and whose loss she had not properly resolved.

Many different losses are suffered by the elderly within a short time span. The aging process brings with it declining physical powers; socially they lose employment, status and finances and at the same time, they have to deal with the deaths of friends and family. They do not have the time to complete grief work before another loss occurs and this can result in 'grief overload'. The elderly tend to somatize grief, presenting many different physical symptoms which may be treated without recognition of the underlying cause. In his study Lindemann (1944) identified stages of grief that appeared to be common across mourners. As with the stages of dying, these can be missed, experienced simultaneously and in a different sequence. These stages have since been broken down into more specific reactions, but these five represent the main areas.

(1) **Sensations of Physical Stress** – tightness in the throat, palpitations, tension, mental pain.

(2) **Sense of Unreality** – increased emotional distance from other people together with an intense preoccupation with the deceased.

(3) **Guilt** – this can evolve from the feeling that something more could have been done or from the sense of relief felt upon death after a long illness.

(4) **Hostility** – anger is felt at the deceased for dying and abandoning them. This anger can be displaced and projected on to those around them.

(5) **Disorientation** – when following the daily routine the mourner discovers that a good part of the day was linked with the deceased, therefore it has now lost meaning. This can lead to strong dependency on anyone who stimulates them to activity until they can establish themselves again.

Whether the stress associated with bereavement is more problematic for men or women, for young or old or for one socio-economic group above another is unclear, but the literature suggests that negative changes in physical and mental health and mortality rates generally accompany widowhood. There are many complicated social and psychological variables that can alleviate these negative changes, including individual character, ways of coping used throughout life, social networks, income, religion and anticipatory grief. It is not possible within the scope of this paper to discuss all the variables; however, social networks and anticipatory grief have particular reference for the elderly.

The belief has been held that anticipatory grief allows for rehearsal and acts as a safeguard against sudden death. However, recent research (Schwab, Gerber et al., in Lemasters, 1978) suggests that for the elderly looking after an ailing or dying spouse for

an extended period produces greater psychological and physical problems than sudden death. Therefore, rather than reducing the grief response, anticipatory grief can in fact compound it.

When looking at the social network available to the bereaved, it is necessary to assess the quality rather than the quantity. It has been suggested that while many of the very old have fewer relatives and friends around them, the quality of support given is very high. The supporters are very often aged 60 and over, retired and with more time for visiting, and their own acceptance of death enables them to face the patient's impending death. Patients facing death at younger ages may have many more people physically present but they are also younger and their attitudes towards death often present problems. In fact they often require as much or even more assistance than the dying patient.

III ENVIRONMENT AND SUPPORT SERVICES NEEDED

There is no one theory to cover all cases, for each individual is unique in the way he/she faces death and bereavement. Professionals in this area, and the programmes they administer, must be able to respond flexibly to the requests and cues of the patient and family. When a patient or family requires help, it cannot be scheduled at certain times of the day; the response must be there no matter where or when. A strong belief in one theory can lead to caregivers imposing their feelings and stages upon those concerned rather than their recognizing true needs.

A. Care of the Terminally Ill

Gustafson pointed out that the dying often go through a social death long before the physical death occurs. When a physician pronounces that "nothing more can be done" (the usual meaning being in the way of curative treatment), this sets the tone for all those around the patient. Studies have shown that nurses take longer to answer the bell of a dying patient, physicians visit less and families sometimes withdraw in preparation for the death. This often means that no one is willing to take responsibility for the dying patient and he/she feels isolated and abandoned.

Weisman and Kastenbaum showed that while there are those who wish to withdraw from life, there are many willing to participate in life until the moment of death if given the means to do so. Unfortunately, it is often forgotten that a 'cancer patient' or 'the old woman' is still a person and that his/her needs are the same as all other humans: "to be loved, to be thought of as someone of worth, and as having something to contribute" (Garrett).

The five stages posted by Kubler-Ross show the complex emotions of both patient and family. It is most important, therefore, that the unit of care should be patient and family so that each may learn to understand the needs and feelings of the other.

Kubler-Ross in *To Live Until We Say Goodbye* (1978) pointed out the four areas of human needs:

It is known that there are four quadrants comprising the human being's personality, namely the physical, spiritual, intellectual and emotional and people can be well if these are in harmony.

Unfortunately, these have sometimes been dealt with as four separate and independent parts rather than interdependent needs in a holistic sense. The physical aspect has received the main emphasis with increasing care placed on emotional needs. However, the intellectual (right to know diagnosis/prognosis, right to take part in decisions) has been overlooked, while the spiritual has been left to the church as something outside the realm of health.

It was in trying to answer these needs that the hospice movement began. It recognized that the dying and bereaved needed specialized care that could not always be given in an acute care setting. The philosophy of hospice care is to answer the physical, psychological, social and spiritual needs of the patient and family in the period leading to death, at the time of death and during bereavement.

Dr. Cicely Saunders, founder of St. Christopher's Hospice, London, England developed the following concepts:

i) Cure System
Investigation and treatment, elimination or control of disease.

ii) Care System
Assessment, relevant investigations, control of symptoms of uncontrollable disease.

(Canada, Department of National Health and Welfare, 1981)

The 'cure' system is aimed at the prolongation of life whereas the 'care' system places its efforts on the quality of the patient's remaining life. It is within the concept of the 'care system' that palliative care[1] falls.

The definition of palliative care as set out in "Palliative Care in Hospitals" (1981) is as follows:

> Palliative care refers to programs or services that provide care to those patients for whom treatment aimed at cure and prolongation of life is no longer appropriate but for whom therapy aimed at improving the quality of the remaining life is the primary objective. Palliative care offers therapeutic services designed to address the physical, psycho-social and spiritual needs of dying patients and their families.

It has been suggested by some that the specialized services should be available only to those experiencing severe symptoms while others state they should be available to all who are dying.

It can be organized in the following manner:

(1) A free standing hospice for in-patient care, including a home care component.

(2) A palliative care unit set up in an existing hospital, and including a home care component.

(3) A palliative care support team working throughout a hospital or group of hospitals, including a home care component.

(Please refer to Appendix I for full details of organization and components).

Palliative care has many facets but pain control and the home care component are two of the most important. Medication is such that pain is alleviated but the patient remains alert and able to participate in life. It is administered on a regular schedule so that pain does not recommence and in this way even the memory of pain can be eradicated. The patient may also have worries regarding his family, business, and so forth and by caring for the total person, these worries, which can contribute to physical pain, are also alleviated.

Helping the patient remain at home as long as possible, and to die there if desired, is paramount and the care units often see themselves as back-up to this component. They stabilize the patient in the beginning and cope when home care is no longer possible. To sustain home care there must be adequate support services available on a twenty-four hour basis for the family must not feel they are alone in dealing with the many problems that can occur.

Dr. Saunders has said:

> We learn about the care of the dying from the dying themselves.

To do this, the art of listening in a non-judgmental way is paramount; this is one of the fundamentals of palliative care.

B. Care of the Bereaved

As the grief process is not fully understood, its effects are often underestimated and unrecognized. Friends, relatives and support services in institutions are available in the interval before and at death but in many cases the survivors then find themselves alone. Many will be told "call me if you need help" but this is often required some time after the death when it is deemed by society that mourning should be finished. It is important for the bereaved to know that grief is a natural, lengthy process and their feelings of anger, depression, disorientation etc. are normal. They should be encouraged to vent emotions that would otherwise be internalized, often to emerge in atypical form at a later date.

Follow-up at intervals is very important so that the bereaved do not feel abandoned. This is doubly important in the case of the elderly who are often reluctant to ask for help as they value their independence. At the same time they may not have family or friends or at least not in close proximity. One of the most successful programs in this regard has been the Widow-to-Widow program where those who have successfully completed grief work visit and help those newlywidowed. It is often easier for the bereaved to open up to another who has suffered the same grief and can emphathize with their feelings.

It is important that major decisions, such as giving up a home, not be made in the first year. The bereaved should be advised of alternative courses of action but allowed to decide for themselves in their own time. At the time of follow-up it can be seen if action upon advice has been taken or if they need further help. If, for example, they have been referred to a group, they may need someone to go with them to the first meeting.

Grief at the death of a spouse is deep, no matter at what age widowhood occurs. One of the differences between ages seems to occur in the types of problems presented. A widow in her twenties with small children may need more immediate help with the children and with getting into the labour force; in her sixties she may need help in those areas where she had relied upon the skills of her husband; in her eighties more concrete helping services are needed, for example, shopping, transportation and so forth, as well as emotional support. For widowers, coping with loss may be even more difficult. They have fewer

close social contacts to draw upon; they may be lacking in housekeeping skills (Abu-Laban, 1980). This is an area where further research is needed.

Although many elderly have prepared for the loss of their spouse, they do need help with the grief and mourning periods for some time after the death. Those with strong social networks, good health and financial stability have a better chance of adapting to the widowed role. Lemasters (1978) has posited the following as indicators by which the "at risk" population can be identified:

- those who have been caring for a dying spouse for more than six months;
- those who have had no previous experience with bereavement;
- those without social supports;
- those who appear severely depressed, angry and so forth, one or two months after the death;
- those with an increased number of physician visits, as the elderly tend to somatize grief.

It is important, therefore, that care-givers be trained to recognize the above in order that services are in place from the outset rather than brought in to answer a crisis.

C. Care of the Frail Elderly

The question posed in the introduction, "is someone aged 85, frail and suffering from one or two chronic diseases in a state of dying?" is difficult to answer. Who actually defines when a person is "dying" and what criteria are used? Little research has been done in this area to ascertain if the frail elderly with their knowledge of approaching death present some of the same stages as those defined as 'terminally ill'. They may not for instance experience the anger and 'why me' stage for they often feel that they have lived a good, long life. Indeed they often fear living too long and becoming a burden. At the same time they may experience some of the depression regarding past losses or omissions in life.

The writer can only surmise that the following would have relevance:

(1) Gustafson's idea of social death occurring prior to physical death. The frail elderly are often in institutions or are housebound, have fewer social contacts and the general attitudes towards aging per se often isolate them. Therefore, care should be taken to extend the social stage as long as possible and care should be taken not to treat them as if they were already dead!

(2) Although most elderly will deal forthrightly with the thought of death, they will still experience the fears of abandonment, pain and have the need to review life in order to find meaning.

(3) The impact of how death is handled in institutions is an important factor (Geriatric Care, 1982). The following can easily depersonalize death:
   - death is not a topic for discussion;
   - the dying patient is isolated and after death the body is taken away quickly and secretly;
   - the patients are not allowed to participate in rituals for the dead or express their personal reactions.

This depersonalized process presents a denial that the patient has lived or has been a part of the community. The patients see how their death will be handled and realize

it will have no meaning and the core of self-respect that has enabled them to face decline and suffering is eroded.

The general philosophy of palliative care, i.e. the emphasis on quality of life, would apply here equally. Death is an ever-present factor for the elderly whether they are at home or in an institution. Frequently they can find some comfort in talking about death and in being able to make arrangements for the disposition of their possessions following death. However, families do not wish to talk about death and often ask other care-givers to avoid the subject and so a 'conspiracy of silence' is maintained. Death should not be dwelled upon, but it must be recognized that the frail elderly have needs and fears in this regard and these should not be ignored.

IV EXISTING SUPPORT SERVICES

The review of existing and planned services in the Province of Alberta is not exhaustive and it is suggested that an in-depth review needs to be carried out, especially in the area of acute care hospitals, auxiliary hospitals, nursing homes and in the rural areas of the Province.

At the present time in Alberta there are two projects setting up palliative care teams in the W. W. Cross Cancer Institute, Edmonton, and the Tom Baker Cancer Clinic, Calgary. These teams include pain control specialists, psychologists and social workers. The Youville Memorial Wing of the General Hospital, Edmonton, has sixteen palliative care beds for those aged 60 and over.

There is great interest and support for the palliative care concept and two committees, Hospice Calgary and Hospice Care Edmonton, are presently working towards the establishment of co-ordinated comprehensive care programs for the dying and their families. They are endeavouring to bring together all agencies presently working in this area in a cooperative effort to meet this goal. Some of the central aims of the committees are:

- Central Administration. To cut out unnecessary cost and increase the quality and quantity of health care for the available dollar.
- Education. To train health care professionals at the undergraduate and postgraduate levels and those working in various agencies: to develop an education package for interested public groups.
- To act as a co-ordination catalyst so that no matter where the patient is located (home, acute care hospital, auxiliary hospital, nursing home) the same supportive caring will be available.

The majority of acute care hospitals, auxiliary hospitals and nursing homes are concerned about the way dying patients are handled and provide support but are often constrained by the lack of staff and lack of education in this area. The biggest problem occurs in the area of bereavement. After the death of the patient the family is often alone and it is not possible for institutions to carry out the type of follow-up that is required.

There are some excellent programs set up in the community to help survivors (applying to all ages, not particularly the elderly); however, many are not aware of their existence

and for some taking the initiative in asking for help is difficult although it would be accepted if offered. There has not been sufficient fiscal support for, training in and understanding of the grieving process and it is felt that this is an area of urgent concern. Existing programs are suffering from lack of funds and staff and therefore cannot expand to meet needs.

Another area of concern is that although there are many services presently in place, lack of co-ordination and central administration and funding often present problems. Both professionals and public are not always aware of what is happening and available. To overcome this, the establishment of hospices, palliative care units or palliative care teams (according to the needs of the area and funding available) was put forward by many working in the field. It was felt that this would provide a catalyst generating knowledge, research, training, co-ordination and also provide a central information point for the public.

Appendix II lists some examples of existing programs in the Province of Alberta.

V CONCLUSIONS

Coping with death, dying and bereavement is a very individual experience, dependent upon many factors. It is known that rates of mortality, morbidity and suicide all rise at widowhood, especially for elderly males (Lemasters, 1980). Certainly more research is required into pain control, symptom relief and the effects of bereavement especially for those 65 and over. At the same time, indepth evaluation is needed of the programs already in place both in Alberta and other provinces so that a co-ordinated care program can be put in place that best meets the needs of patients and families.

Education is of vital importance for both health professionals and the public. It is interesting to note, in this connection, that the Family Services Association in Edmonton is working with the Edmonton Separate School Board to present courses in loss in Grade 8. Learning to deal with loss, whether it is through death, divorce, loss of job, loss of possessions, at an early age will help in establishing coping mechanisms and bring about a more open attitude to death and bereavement.

In *An Anglican Contribution to the Debate on Euthanasia* (1975) the following argument was put forward which supports palliative care:

> To say that every active intervention should be pursued to the end is as wrong and heartless as saying "there is nothing more to be done" and abandoning the patient.

It is difficult for all concerned to make the decision not to employ 'heroic efforts' however the best interests of the patient might indicate this measure. Many of those asking for death are, in reality, asking for release from pain and loneliness. Palliative care can achieve this.

When looking at death and dying in connection with the elderly, it is important to remember the added complication of ageism. It becomes necessary to deal with the negative attitudes towards the aged and the view that their death is not as tragic or important as the death of a young person. Death is expected in old age but this does not necessarily mean that the process is any easier for the patient or family. If the narrow definition of palliative care "for those experiencing severe symptomology" is accepted, this could eliminate the majority of dying from the caring they need. It is imperative, therefore, that the general philosophy of palliative care be introduced throughout the health care system for:

> You matter because you are you. You matter to the last moment of your life and we will do all we can, not only to help you die peacefully but also to live until you die.
>
> (Dr. Cicely Saunders, in Kent, 1981)

For the bereaved it is necessary to recognize the lengthy process involved, the serious effects on physical and mental health and for the aged, the problems of 'grief overload'. Education and training for health care professionals, social workers, counsellors and volunteers are needed so that they can respond to the verbal and non-verbal cues of the elderly bereaved.

Modern technology has brought many benefits, the prolongation of life being one, but it must be recognized that in some cases, it is more a prolonging of death. The difference

between the two is a very fine line indeed and needs careful assessment. The trend towards a holistic approach is growing and the writer cannot express the need more concisely than to quote a professional in the field who said:

> What we need is a transition from intensive care to intensive caring.

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FOOTNOTES

1. From palliate, to alleviate or lessen (disease) without curing. The Gage Canadian Dictionary.

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APPENDIX D

CHAIRMAN'S REPORT ON WORLD ASSEMBLY

1982 Report
Provincial Senior
Citizens Advisory
Council

CHAIRMAN'S REPORT ON WORLD ASSEMBLY

The United Nations World Assembly on Aging was held in Vienna July 26 – August 6, 1982 with representation present from 120 nations. Its objective was to launch an international action program aimed at guaranteeing economic and social security to older persons, and guaranteeing opportunities for the aged to contribute to national development.

The Assembly was conducted in two sessions running concurrently. One, the General Debate, was a series of addresses by heads of delegations giving in some detail the positions of their governments and their countries concerning the aged. The other, the Main Committee, was a continuing meeting of representatives of the attending nations to draft an International Plan of Action. One of the striking features of both sessions was the commitment and sincerity of those participating. Only on rare occasions was the forum used to pursue strictly political positions. Those taking part in the General Debate were consistent in their concern with the implications of demographic projections, recognizing they were already underway. Both developed and developing countries shared the need to act now, although the developed ones were considered more vulnerable. Indeed it was pointed out that the developing countries may benefit from some of the mistakes of the developed countries and might for example place less emphasis on senior governments for the well-being of the aged and more on families and communities. They might also learn how to retain the aged as an active part of society rather than setting them aside. A realistic plan of action was seen as an essential tool and one that each nation would be prepared to support. The similarity of the problems, and the determination to act in support of the aged was remarkably consistent among the speakers, although of course each nation reserved the right to respond according to its own circumstances.

An international sub-committee had worked in advance to prepare a draft of the Plan of Action. The draft document was studied and discussed in detail by the main committee during the entire conference time. It was a very difficult assignment as consensus had to be reached with the 120 delegations and in six languages. However, the delegates were committed to the completion of their assignment and with some overtime sessions the redraft was ready for presentation to the World Assembly in its final plenary session. It was adopted unanimously and will be submitted to the General Assembly of the United Nations for ratification.

It is interesting to note the similarity in thrust among the recommendations of the Plan of Action, the recent Symposium on Aging held in Edmonton in June of this year and our own Council's reports in this and previous years. It would seem that we have fairly well-developed guidelines for future planning and programming. We now need initiative, primarily from governments, to work out the actual process of translating our plans of action into programs in action.

To this end the Honourable Monique Begin, Minister of National Health and Welfare, plans to convene a Canadian Assembly on Aging within a year of the World Assembly.

APPENDIX E

DESIGN FOR AN ALBERTA INSTITUTE ON AGING

1982 Report
Provincial Senior
Citizens Advisory
Council

September, 1982

A DESIGN FOR AN ALBERTA INSTITUTE ON AGING

Purpose

I. WHAT IS THE PROPOSED INSTITUTE?

It would be an organization to advance knowledge about aging and the aged, and through the application of this knowledge, to improve the quality of life for older people.

Numbers and Percentage of Elderly Increasing

II. WHY HAVE AN INSTITUTE?

The numbers and percentage of elderly are increasing and will continue to increase over the next fifty years. It is projected that the number in the 65 and over age group will almost double in Alberta by the year 2001 and those 65 and over, now approximately 9 per cent of the Canadian population, may comprise 20 per cent in the year 2031.* As more people live longer, they will be needing and using increasing amounts of pension and income benefits, hospital and medical services, housing and social services, education and recreational programs. If we continue to provide services in the present manner, we will be continuing to respond to problems on a crisis basis with resulting prohibitive costs.

Lack of Planning Will Increase Cost

However, cost is not our primary concern. Our primary concern is quality of life. Presently, our policies, in reality, force many older persons out of the sphere of normal adult life who should not and need not be forced out.

Essential to Acquire and Apply Knowledge to Ensure Good Quality of Life for Aging Persons

Ways must be found to ensure that in future the increasing numbers of older persons will not form a depressed segment of society. They must be able to continue to participate; indeed their resources will be likely needed.

More knowledge and new knowledge gained through research, with a commitment to use that knowledge for the benefit of the elderly, is essential to ensure that more older persons will be able to preserve their physical and mental well-being. Furthermore, research in the aging process will have significance not only for older persons but for persons of all ages in our society.

There is no organization at present equipped to devote major resources to research in aging. Existing bodies would require a major shift in emphasis and structure and would need to be given the resources and mandate to develop this new direction. Establishing a new organization, an Alberta Institute on Aging, is perceived as the most effective means of accomplishing what

* Statistics Canada, Canada's Elderly, Ottawa, March 1979.

is required. This body could bring together and promote the work of persons in various disciplines and professions, and help use their combined expertise to improve the quality of life of future generations of elderly — our "future selves" since ultimately we will all grow old if we survive.

III. WHAT WOULD BE THE MANDATE OF AN INSTITUTE?

Mandate

An Institute could

- stimulate and carry out basic, applied and evaluation research in aging,
- provide a knowledge base for the long-range planning of the delivery of services to the aged;
- significantly influence the education of health and social service professionals working with older persons and increase understanding of aging in the general public.

As well as serving Alberta, the Institute would have the capacity to develop a national and international reputation. By investing in such a long-range research and educational body, Alberta could make a major contribution toward the well-being of all older Canadians.

IV. WHAT WOULD AN INSTITUTE DO?

Research

Under the direction of its governing body:

i) The Institute would carry out basic, applied and evaluation research in aging, for example, in the biological, the behavioral, the sociological, the environmental, the epidemiological, the pharmaceutical aspects of aging, as the basis for long-range planning. It could look at age-related diseases and their control. It could study the cost benefits of existing services as well as their knowledge base. It could look at the components of successful aging.

It would

- establish research priorities;
- on the basis of these promote and conduct research, providing contracts, joint appointments when appropriate;
- encourage other bodies to fund and conduct research in aging;
- conduct research upon request from other bodies, including government;
- stimulate needed research by providing grants-in-aid of research, upon application (see VI, Endowment for Operating and Research Funds);
- advise on the development of research proposals.

Education

ii) An Institute would stimulate, consult and cooperate in the development of education about aging and old age. It would,

however, not duplicate or supplant existing educational programs nor would it provide degree or certificate programs or courses.

It would, among other things,

- work with existing institutions by providing joint appointments, for example, with the universities and, as requested, advise on curricula in aging in undergraduate and graduate faculties, with particular emphasis on the development of gerontological content in professional faculties;
- provide bursaries for doctoral and postdoctoral study at the universities, particularly for the development of researchers and educators;
- promote and/or conduct symposia and special educational programs;
- arrange opportunities for study at its resource centre (see IV, iii), for example, for those on sabbatical leave and for students;
- develop educational programs on aging for the general public in cooperation with existing educational institutions.

Gerontological Resource Centre

iii) An Institute could provide a gerontological resource centre which would collect and disseminate gerontological data and information particularly with reference to Canadian research and service developments. Its library could have essential periodicals and books, links with other libraries and data centres, as well as a collection of audio-visual materials.

Communication Advice and Interpretation

iv) One of the most important aspects of the work of an Institute would be the sharing of up-to-date information and knowledge on aging with the public. This could include education programs, the work of its resource centre, as well as the publication of papers and research studies. In this way, and by providing advice and interpretation of research results as needed, an Institute would enhance communication and the application of knowledge about aging.

Start Slowly in One Area—Research

v) In the beginning an Institute would concentrate on one area, possibly promoting and initiating research through grants-in-aid of research and communicating research findings. Other areas could be added once a good foundation is established. An Institute would not provide direct service, but would through research and communication improve the quality of services provided by other bodies.

V. HOW WOULD AN INSTITUTE BE ORGANIZED?

Reporting Relationship

i) An Institute would be established through legislation. It would report to the government through the Minister of Social Services and Community Health.

Board of Directors: Policy Component

ii) An Institute would be managed by a Board of Directors appointed from the public-at-large by the Lieutenant Governor in Council. Members could be appointed on a three or five year rotating basis. An executive management committee from among the Board of Directors would be appointed to advise, assist, and when necessary direct the executive staff in the day-to-day operation of an Institute. It might be advisable to consider having, as either full or ex officio members of the Board, one or two representatives from the universities and one or two senior government officials. This would ensure effective communication and working relationships with two important sectors.

Scientific Advisory Committee: Expert Component

iii) The Board would appoint a scientific committee to meet as required to provide expert gerontological advice concerning program development. Appointments could be for three year terms on a rotating basis. The committee would advise, in particular on research priorities and applications for research grants. The Board would appoint to this committee scientists and professionals in the area of gerontology from a variety of disciplines. Preference would be given to persons with international reputations in both gerontology and research. It may be necessary for the Board to appoint an interim committee to assist in the first stages until the formal committee is appointed.

Staffing

iv) It would take up to ten years for the Institute to mature. Initially it would require six to eight persons to staff it — an executive director, a staff person or persons for its first area of work, and financial, public relations and secretarial help.

Much of the staff work could be done on a contract or joint appointment basis, for example, with the universities, other educational institutions and community agencies.

Executive Director of National/International Reputation

v) Since the Institute would be a unique development in Canada, the executive director, in addition to being a capable administrator, should be professionally recognized and known internationally for his or her work in gerontology. This person and other initial staff should have the stature that makes them acceptable to the university and other intellectual communities. It may be advisable initially to appoint the director and other senior staff on contracts.

VI. HOW WOULD AN INSTITUTE BE FUNDED?

Endowment for Operating and Research Funds from Both Public and Private Sources

To provide a secure income for the operating costs, the grants-in-aid of research and fellowships, an Institute could be funded through an endowment established initially through the Heritage Savings Trust Fund. Based on work done by the Steering Committee for an Institute, it is proposed that this be a one-time endowment of up to $30 million (1982). No capital funding would be required.

As an Institute matures, it should make a major effort to seek funding from private sources (for example, business and industry). In all probability no further government funding, other than possible contracts for research, would be required.

The majority of the endowment income should be reserved for research grants and fellowships as the operating costs of an Institute need not be large.

VII. HOW WOULD AN INSTITUTE BE ACCOUNTABLE?

Annual Report and Evaluation after Five Years

An Institute should provide annual reports of its activities and finances to the Standing Committee on the Alberta Heritage Savings Trust Fund Act. External, impartial review of the productivity of an Institute should be carried out periodically.

VIII. WHERE SHOULD AN INSTITUTE BE LOCATED?

The Institute should be located in a community which has:

1. a major university with a Faculty of Medicine and a health science complex, library and computer facilities;
2. the availability of a variety of social and health programs;
3. easy accessibility for national and international visits;
4. the amenities of a large population centre.

Unique Outreach Model: Benefits to Many Communities

The Institute could have the capacity to reach out to many parts of Alberta, and in this way be able to affect many communities. It may do this by providing joint appointments for teaching and research with a variety of educational institutions and agencies and by conducting research in various parts of the province.

IX. HOW WOULD THE CREDIBILITY OF AN INSTITUTE BE ASSURED?

Credibility for an Institute

To ensure the credibility of an Alberta Institute, it is essential for the initial professional staff to have an excellent national and even international reputation. Gerontology is a new area of work and because of this there are only a few people who could be considered appropriate for the position of executive director and even some of the other key positions. These people are in great demand throughout North America and have many professional opportunities. The Board of the Alberta Institute on Aging would have to recruit the initial staff most carefully to be certain an Alberta Institute starts on a solid and reputable basis.

X. WHAT WOULD ALBERTA GAIN BY HAVING AN INSTITUTE?

Benefits

Not only would an Institute give Alberta a national and even an international reputation in the field of aging, its work should result in Alberta responding more effectively to the social and economic implications of an aging population and to the specific needs of older persons.

Submitted by the
Provincial Senior Citizens
Advisory Council

September, 1982

APPENDIX F

LIST OF 1982 COUNCIL MEMBERS,
TERMS OF REFERENCE AND
STATEMENT OF PHILOSOPHY

PROVINCIAL SENIOR CITIZENS ADVISORY COUNCIL 1982

Chairman
Duncan Rogers, Calgary

Calgary
John P. Donahue
Hazel McDonald

Edmonton
Milton McInnis
Grace Smith

Grande Prairie Area
Arta Juneau

Lethbridge Area
Erna Goertzen

Medicine Hat Area
Desmond O'Coffey

Red Deer Area
Norman Bowles

Rural Areas
Ray Clark
Burdett

Muriel Oslie
Peace River

Representing the Alberta Hospital Association
Edward F. Fee
Killam

Representing the Universities
Dr. Sharon Abu-Laban
University of Alberta, Edmonton

Member of the Legislature
Norm Magee
Red Deer

Representing Government Departments
Amelita A. Armit
Assistant Deputy Minister
Planning Secretariat
Social Services and Community Health

Dr. Don Orn
Coordinator, Gerontological Services
Hospitals and Medical Care

Julian Nowicki
Assistant Deputy Minister
Recreation Development Division
Recreation and Parks

Bill Novasky
Director, Health and Social Services Programs
Advanced Education and Manpower

Murray Rasmussen
Deputy Minister of Housing
Housing and Public Works

PROVINCIAL SENIOR CITIZENS ADVISORY COUNCIL

Terms of Reference

Purpose

1. To review the views and concerns of older persons in Alberta.
2. To foster positive attitudes towards aging and a better understanding of old people.
3. To provide advice to the government on specific policies and programs for senior citizens and to advise in regard to priorities and the co-ordination of programs.
4. To make any other observations to the government deemed to be relevant to the development of programs for older people.
5. To review and advise on educational and special projects grants for programs for senior citizens, subject to the availability of funds.
6. To carry out other responsibilities at the request of the government from time to time.

Structure

Meetings:

The Council will meet not less often than four times a year.

Reporting:

The Council shall submit an annual report to the Minister responsible for the Council at the end of each calendar year and submit any other reports to the Minister deemed appropriate.

Remuneration of the Chairman and Members of Council:

Remuneration, honoraria and out-of-pocket expenses will be according to the appropriate schedule established by Ministerial Order. Honoraria will not be paid to public servants.

Secretariat:

The Director of the Senior Citizens Bureau will act in this capacity and the resources of this office will be available to the Council.

Membership

- Chairman to be appointed by government and to hold office at the pleasure of the government
- representative, Advanced Education and Manpower
- Deputy Minister of Housing
- Assistant Deputy Minister, Recreation and Parks
- Assistant Deputy Minister, Social Services and Community Health
- representative, Hospitals and Medical Care
- one member from each of the following organizations selected from nominations put forward by them: Alberta Hospital Association, Alberta Medical Association, and on an alternative basis, the University of Calgary, the University of Alberta and the University of Lethbridge
- one Member of the Legislature.
- ten members representing the community.

PROVINCIAL SENIOR CITIZENS ADVISORY COUNCIL – ALBERTA STATEMENT OF PHILOSOPHY

The Council believes that old age should be a time of satisfaction and fulfilment.

Like persons of all ages, older persons should be able, within reason, to select their own lifestyles, influence and determine their futures, and have an opportunity for meaningful involvement. They should be able to enjoy a sense of security from appropriate health and social services and be assured of financial and other resources that enable them to share in a rising standard of living. They also have a responsibility to be as self-reliant as possible and contribute to the well-being of society.

Even though the later years may bring physical and social stresses, the Council believes that they can be a time of productivity, growth and self-realization.

To ensure this, three basic themes should form the foundation of government policy, services and their delivery:

1. provision for maximum independence and choice;
2. encouragement of continued participation in family and community life;
3. involvement of senior citizens in the planning, development and assessment of services.

The Council is convinced that it is in the interest of all people that the positive aspects of aging and old age be stressed. Through programs and policies which encourage activity and contribution, senior citizens can be a vital component of the social fabric of this Province.